Primecare Link Services LLC
Application/ Orientation Packet

Today's Date: _____

Personal Data

Email Address: _____

Last Name	First Name	Middle	SSN

Home Address	City	State	Zip

Home Phone	Cell Phone	Email

Position Applied for: (Select One)

☐ Personal Care Attendant

☐ Other (Specify) _____

Education

Name of High School			
From **To**	**Did you graduate?** **Yes** ☐ **No** ☐		**Degree**
Name of College			
From **To**	**Did you graduate?** **Yes** ☐ **No** ☐		**Degree**
Other			
From **To**	**Did you graduate?** **Yes** ☐ **No** ☐		**Degree**

Emergency Contact Information

Name of Emergency Contact	Relation	Emergency Telephone Number

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

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Holidays available to work: ☐ Yes ☐ No Comments _____

☐ Date available to start work: _____

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REFERENCES:

PROFESSIONAL REFERENCES:
(Previous Personal Assistance Services Employer)

Full Name:_____

Position: _____

Phone Number: _____ Ext: _____

Can we contact them? ☐ Yes ☐ No _____

FOR OFFICIAL USE Reference Verified	☐Yes	☐ No	☐ NA
Date of Reference Contacted			
Contacted By		Signature:	

PROFESSIONAL REFERENCES:
(Previous Personal Assistance Services Employer)

Full Name:_____

Position: _____

Phone Number: _____Ext: _____

Can we contact them? ☐ Yes ☐ No _____

FOR OFFICIAL USE Reference Verified	☐Yes	☐ No	☐ NA
Date of Reference Contacted			
Contacted By		Signature:	

PERSONAL REFERENCES:

Full Name:_____

Relationship: _____

Phone Number: _____

Can we contact them? ☐ Yes ☐ No _____

FOR OFFICIAL USE Reference Verified	☐Yes	☐ No	
Date of Reference Contacted			
Contacted By		Signature:	

PERSONAL REFERENCES:

Full Name:_____

Relationship: _____

Phone Number: _____

Can we contact them? ☐ Yes ☐ No _____

FOR OFFICIAL USE Reference Verified	: ☐Yes	☐ No	
Date of Reference Contacted			
Contacted By		Signature:	

Employment History:

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

WORK EXPERIENCE 1:

Company Name:_____

Position: _____ Pay/Hour $_____

Start Date: _____ End Date: _____

Duties & Responsibilities:

_____
_____
_____
_____
_____
_____
_____

_____

WORK EXPERIENCE 2:

Company Name:_____

Position: _____ Pay/Hour $_____

Start Date: _____ End Date: _____

Duties & Responsibilities:

_____
_____
_____
_____
_____
_____
_____
_____

WORK EXPERIENCE 3:

Company Name:_____

Position: _____ Pay/Hour $_____

Start Date: _____ End Date: _____

Duties & Responsibilities:

_____
_____
_____
_____
_____
_____
_____
_____

Please list any other work related information you think would be helpful to us in considering you for employment, such as specialized training, certifications, additional work experience, etc.

_____

_____

_____

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Additional Information:

1. Are you legally authorized to work in the USA? ☐ Yes ☐ No
2. Have you ever been convicted of a felony? ☐ Yes ☐ No
3. Can you pass a pre-employment drug test? ☐ Yes ☐ No
4. How were you referred to Primecare Link Services LLC?
   ☐ Newspaper ☐ Trade Publication ☐ Job Fair/Open House ☐ Internet Site

   ☐Company Employee – Name: _____ ☐ Other _____

I understand that **I must** report all accidents to my immediate supervisor **and** to Primecare Link Services LLC - - No MATTER HOW SLIGHT.
☐ Yes ☐ No

I also understand that I must wear all required personal protection equipment (PPE). ☐ Yes ☐ No
The penalty for not wearing PPE is disciplinary action, up to and including termination.

Applicant Signature _____

ACKNOWLEDGMENT (*Please read carefully and sign*)

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

I give Primecare Link Services LLC permission to use any information in this application to enable it and its agents to verify the information contained in this application I also authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by Primecare Link Services LLC with regard to any of the subjects covered by this application. I also understand that in connection with my application for employment or my employment, Primecare Link Services LLC may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release Primecare Link Services LLC, its agents, and all affiliated entities, as well as any person or situation that provides any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information. This agency will check the employee misconduct registry (EMR) maintained by DADS. As required by TAC 93.3 and Chapter 253, Texas Health and Safety Code.

In consideration of my employment and of my being considered for employment by Primecare Link Services LLC, I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I also understand that if employed, I will be an employee at will and employed for no definite period of time. I understand that either Primecare Link Services LLC or I can terminate my employment at any time, with or without cause and with or without advance notice. I further understand that no communication, whether oral or written, by any representative of Primecare Link Services LLC, at any time, can constitute a contract of employment. No representative or agent of Primecare Link Services LLC, has the authority to enter into any agreement for employment for any specific period of time or to make any agreement contrary to the foregoing.

I am willing to submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in accordance with the applicable laws. If I receive an offer of employment I agree that my continued employment may be contingent on the results.

I understand that Primecare Link Services LLC is not involved in the day-to-day supervision or decision concerning patient care or dentistry. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies Primecare Link Services LLC against any and all liability and responsibility associated with his or her professional duties. The Professional maintains his or her license as required by law, professional liability coverage and other responsibilities as found under state prime contract law.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Applicant Signature _____ Date _____

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Statement of No Conviction or Criminal Offense

A. I _____ do hereby attest that:

a) ☐ I have ☐ Have not been convicted of any felony. ***(Circle one)***

b) ☐ I have ☐ Have not been convicted of any misdemeanor. ***(Circle one)***

If yes state date(s) of conviction:

a) _____

b) _____

c) _____

B. I also attest that I have never been convicted of any the conviction(s) barring employment listed below:

(a) Conviction(s) barring employment ***(Initial 1 - 14)***

_____ (1) an offense under Chapter 19, Penal Code (criminal homicide);

_____ (2) an offense under Chapter 20, Penal Code (kidnapping and unlawful restraint);

_____ (3) an offense under Section 21.11, Penal Code (indecency with a child);

_____ (4) an offense under Section 22.011, Penal Code (sexual assault);

_____ (5) an offense under Section 22.02, Penal Code (aggravated assault);

_____ (6) an offense under Section 22.04, Penal Code (injury to a child, elderly individual, or disabled individual);

_____ (7) an offense under Section 22.041, Penal Code (abandoning or endangering child);

_____ (8) an offense under Section 22.08, Penal Code (aiding suicide);

_____ (9) an offense under Section 25.031, Penal Code (agreement to abduct from custody);

_____ (10) an offense under Section 25.08, Penal Code (sale or purchase of a child);

_____ (11) an offense under Section 28.02, Penal Code (arson);

_____ (12) an offense under Section 29.02, Penal Code (robbery);

_____ (13) an offense under Section 29.03, Penal Code (aggravated robbery); or

_____ (14) a conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed under Subdivisions (1)-(13).

C. I hereby certify that, to the best of my knowledge, the provided information is true and accurate.

Employee Signature:_____ Date: _____

Administrative Signature: _____ Date: _____

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CONSENT TO PERFORM CRIMINAL AND BACKGROUND HISTORY CHECKS IN COMPLIANCE WITH THE FCRA (Fair Credit Reporting Act)

Each applicant, staff member, or volunteer who is to be screened must sign an authorization form, giving approval for Primecare Link Services LLC to perform a criminal background check.

1. I _____, the undersigned, hereby give my permission for Primecare Link Services LLC to obtain information relating to my criminal history record. The criminal history record, as received from the reporting agencies, may include arrest and conviction data, as well as, plea bargains, deferred adjudications, and delinquent conduct committed as a juvenile. Information obtained may also include any charges pending or not disposed of.

   (Initial 2 -5)

2. _____ I understand that this information will be used, in part, to determine my eligibility for an employment position with this organization.

3. _____ It is my understanding that Primecare Link Services LLC will rely on information provided by the Texas Department of Public Safety, (DPS) or a private data broker pursuant to Health and Safety Code, Chapter 250 perform criminal history checks.

4. _____I understand that Primecare Link Services LLC will not release my record to me, but they can discuss anything contained thereon with me, and that if I have questions regarding the information contained therein, I must contact the reporting agency in order to clarify such information.

5. _____I understand that this form in no way constitutes legal advice, and that if I require any legal advice, it shall be obtained privately and at my own expense.

Applicant Name : _____

Applicant Signature _____ Date:_____

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CONFIDENTIALITY AGREEMENT

It is the responsibility of all Healthcare workforce members, including employees, medical staff, and office staff to preserve and protect confidential patient, employee and business information.

The Federal Health Insurance Portability Accountability Act (the "Privacy Rule"), govern the release of patient identifiable information by home health agencies and other health care providers. These laws establish protections to preserve the confidentiality of various medical and personal information and specify that such information may not be disclosed except as authorized by law or the patient or individual.

Confidential Patient Care Information includes: Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental, or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information. (Note: this information is defined in the Privacy Rule as "protected health information.") Examples include, but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Computer and department based computerized patient data; and
- Visual observation of patients receiving medical care or accessing services; and
- Verbal information provided by or about a patient

Confidential Employee and Business Information includes, but is not limited to, the following:

- Employee home telephone number and address:
- Spouse or other relative names;
- Social Security number or income tax withholding records;
- Information related to evaluation of performance;
- Other such information obtained from the Agency records which if disclosed, would constitute unwarranted invasion of privacy; or
- Disclosure of Confidential business information that would cause harm to Primecare Link Services LLC.

I understand and acknowledge that:

1. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/or peer review activities.
2. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to Primecare Link Services LLC and its affiliates, including business, employment and medical information relating to our patients, members, employees and health care providers.

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CONFIDENTIALITY AGREEMENT

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

4. Primecare Link Services LLC Administration performs audits and reviews patient records in order to identify inappropriate access.

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

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

7. I understand that any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.

8. My obligation to safeguard patient confidentiality continues after my termination of employment with the Primecare Link Services LLC.

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

Dated: _____ Employee Signature: _____

Print Name: _____

Department/Role: 1. ☐ Personal Care Attendant
(Circle one)
2. ☐ Other: _____

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EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM

Employee Name: _____ **Employee SSN: _____ - _____ - _____**

I hereby authorize **Primecare Link Services LLC** (Employer) to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account as follows:

	PRIMARY	**SECONDARY**
Bank Name:	_____	_____
Bank Routing Number:	_____	_____
Name on Account:	_____	_____
Type of Account:	_____ (Checking or Savings)	_____ (Checking or Savings)
Account Number:	_____	_____
Indicate Specific Amount:	$_____	$_____
Or Indicate Percentage:	_____%	_____%

at the financial institution(s) as indicated. I further authorize the financial institution named in this authorization form to credit and/or debit such account(s).

I understand that this authorization remains in effect until the "Employer" receives from me, in writing, notification to terminate the authorization in such a time and a manner as to afford the "Employer" and my financial institution a reasonable time to act upon it. I acknowledge that I have been informed that it will take a reasonable amount of time (up to 15 business days) to complete the initial set up for my bank and particular account and that all paychecks prior to the full implementation will be delivered to me as fully negotiable paychecks.

_____	_____
Employee/Account Holder Signature	Joint Account Holder Signature (if required)
_____	_____
Type or Print Name - CLEARLY	Type or Print Name – CLEARLY
_____	_____
Date Authorized	Date Authorized

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NEW HIRE NOTICE OF MINIMUM WAGE

Overview

TWC provides information to employers and employees about their respective rights, duties and remedies under the Texas Minimum Wage Act.

Current Minimum Wage

Texas adopts the federal minimum wage rate. Effective July 24, 2009, the federal minimum wage is $7.25 per hour.

Effective **September1, 2019**: DADS employers must pay at least **$8.11 per hour** to all employees. Attendants hired on or after September 1, 2019, must be notified of the minimum wage within 3 days of hire.

With specified restriction, employers may count tops and the value of meals and lodging toward minimum wage. An employer does not need to pay an employee who lives on the business premises for on-call time in addition to assigned working hours.

Earnings Statement

Employers must provide employees on a written earnings statement information that enables employees to determine from a single document whether they have been paid correctly for a given pay period. Employers must provide employees on a written earnings statement information that enables employees to determine from a single document whether they have been paid correctly for a given pay period.

Employee Signature: _____ Date: _____

Payment Rate and Schedule Acknowledgement

I have received information that tells me the following

- My pay rate is $__9:00_____/hr
- Pay period is Biweekly

Print Employee Name_____

Employee Signature _____ Print Date _____

Administrator/Supervisor Signature:_____ Date: _____

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Tuberculosis Education/Questionnaire

The CDC has changed the requirements if a Health Care Worker (HCW) is exposed to TB. They now require a Tuberculin Skin Test (TST) be placed once exposure is confirmed and then again in 8-12 weeks. Having a "current" TST does not exclude a HCW from this requirement.

Please read over these facts about TB

- Tuberculosis (TB) is a disease which usually affects the lungs. It is spread from person to person through the airborne route when a person who has active disease coughs, sneezes or speaks.
- TB is caused by a bacterium called Mycobacterium Tuberculosis. If not treated properly TB can be fatal. Symptoms of TB include feeling of weakness, weight loss, fever, night sweats, chest pain, and coughing up blood.
- To prevent the spread of TB, HCW's caring for patients with TB need use appropriate respiratory protection (N95 particulate respirator). Transmission of TB has been associated with close contact of infectious patients by HCW's during cough-inducing procedures, like a bronchoscopy.
- Not everyone infected with TB becomes sick. There are 2 different TB related conditions; latent TB and active TB disease. People with latent TB have the TB germs in their bodies but are not sick because the germs are not active. They do not have symptoms of TB and cannot spread the germs to others although they may develop TB in the future. People with active TB are sick from the germs that are active. They usually have symptoms of TB and are capable of spreading the germs to others. People with active TB can be prescribed medication to help treat the disease.
- TB can be treated with medication. People taking medication for TB need to take the medication exactly as they are instructed. People who do not take the medication as prescribed or who stop the medication too soon may become sick again, and the germs that are still present in them may become resistant to the medication and more difficult to treat.
- People who are most likely to get sick from TB are; people with HIV, people who inject illegal drugs, babies/young children, the elderly, people who were not treated correctly for TB in the past, and people with certain chronic medical conditions.
- Patients with suspected or confirmed TB need to be placed in private rooms with negative airflow or HEPA filter units, on Airborne Precautions, and with the door closed.

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Tuberculosis Education/Questionnaire

Please check Yes or No if you have a NEW onset of the following symptoms and return this form to the Employee Health Department. Additional screening may be necessary depending on your symptoms. Do you currently have any of the following symptoms?

Symptom Description	Yes	No
Fatigue, malaise		
Unexplained weight loss		
Anorexia, loss of appetite		
Fever		
Night Sweats		
Productive cough lasting more than 2 weeks		
Spitting up blood		
Chest pain		
Have a disease or taken medication which affects your immune system.		

If yes, please explain:

_____

_____

I understand that if I develop any of these symptoms or believe that I was in contact with a patient who has TB, I should call Administrator immediately. If I have any questions, I can call the Administrator at 214-560-8247/ 214-475-5735.

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

Print Employee Name_____

Employee Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

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INFECTION COTROL GUIDELINES

The following guidelines provide uniform instructions for all home care staff and family members to prevent the transmission of infection when working with all home care clients.

Guidelines:

1. Assume that all blood and body fluids from all clients/patients are potential infections
2. Hands must be washed before and after contact with each client/patient, and before preparing food. Hands should be washed under a steady stream of warm water with soap or antibacterial fluid for at least one minute. Dry hands completely.
3. Gloves must be worn when coming in contact with blood or body fluids. These fluids include but are not limited to:
    a. Feces
    b. Vomitus
    c. Urine
    d. Oral secretions
    e. Respiratory secretions
    f. Secretions from open wounds

    When gloves are removed, hands should be thoroughly washed again. Gloves do not take the place of hand washing. Remove gloves by grasping the top and peeling them off, folding the fingers into the glove and turning the glove inside out. Discard the gloves. Never reuse gloves.

4. Bed linens, towels, and clothing soiled with urine, stool, or any body fluid should be placed in a plastic bag and tied shut until ready to be laundered. Wash all soiled items in hot, soapy water. Dry on high heat.

5. Dispose of urine, stool, and vomitus by flushing in toilet.

6. Clean bedpan or commode bucket and rinse with a 1:10 bleach solution. (Mix % cup bleach and 2 1/4 cups water). Use a fresh solution daily.

7. Dispose of gloves and incontinent padding in a sealed plastic bag. Place this bag inside household trash bag.

8. Wash all eating utensils in hot soapy water.

I have read and understood these infection control guidelines.

_____

Print Employee Name

_____ _____/_____/_____

Employee Signature Date

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How To Report Complaints, Abuse, Neglect or Exploitation

The individual and LAR (Legal Agent Representative) and Attendant were informed, orally and in writing on how to report complaints and allegations of abuse, neglect or exploitation before service initiation and Annually.

To report complaints, abuse, neglect or exploitation you may call:

1. Primecare Link Services LLC Administrator - **Sara** at **(214) -560 - 8247-**

   Or

2. Primecare Link Services LLC Alternate Administrator - **Joseph** at **(214) - 475 - 5735.**

3. **Texas Department of Family and Protective Services** at **1-800-252-5400**

   And

4. **Department of Aging and Disabilities Consumer Rights Services Division** at **1-800-458-9858**.

Print Employee Name_____

Employee Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

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HEPATITIS B VACCINE

WHAT YOU NEED TO KNOW

1 Why get vaccinated?

Hepatitis B is a serious disease.
The hepatitis B virus (HBV) can cause short-term (acute) illness that leads to:

- loss of appetite
- diarrhea and vomiting
- tiredness
- jaundice (yellow skin or eyes)
- pain in muscles, joints, and stomach

It can also cause long-term (chronic) illness that leads to:

- liver damage (cirrhosis)
- liver cancer
- death

About 1.25 million people in the U.S. have chronic HBV infection.

Each year it is estimated that:

- 80,000 people, mostly young adults, get infected with HBV
- More than 11,000 people have to stay in the hospital because of hepatitis B
- 4,000 to 5,000 people die from chronic hepatitis B

Hepatitis B vaccine can prevent hepatitis B. It is the first anti-cancer vaccine because it can prevent a form of liver cancer.

2 How is hepatitis B virus spread?

Hepatitis B virus is spread through contact with the blood and body fluids of an infected person. A person can get infected in several ways, such as:

- by having unprotected sex with an infected person
- by sharing needles when injecting illegal drugs
- by being stuck with a used needle on the job
- during birth when the virus passes from an infected mother to her baby

About 1/3 of people who are infected with hepatitis B in the United States don't know how they got it.

3 Who should get hepatitis B vaccine and when?

1) Everyone 18 years of age and younger
2) Adults over 18 who are at risk

Adults at risk for HBV infection include:

- people who have more than one sex partner in 6 months
- men who have sex with other men
- sex contacts of infected people
- people who inject illegal drugs
- health care and public safety workers who might be exposed to infected blood or body fluids
- household contacts of persons with chronic HBV infection
- hemodialysis patients

If you are not sure whether you are at risk, ask your doctor or nurse.

✓ **People should get 3 doses of hepatitis B vaccine according to the following schedule.** *If you miss a dose or get behind schedule, get the next dose as soon as you can. There is no need to start over.*

Hepatitis B Vaccination Schedule		WHO?		
		Infant whose mother is infected with HBV	Infant whose mother is *not* infected with HBV	Older child, adolescent, or adult
WHEN?	First Dose	Within 12 hours of birth	Birth - 2 months of age	Any time
	Second Dose	1 -2 months of age	1 - 4 months of age (at least 1 month after first dose)	1 - 2 months after first dose
	Third Dose	6 months of age	6 - 18 months of age	4 - 6 months after first dose

- The second dose must be given at least 1 month after the first dose.
- The third dose must be given at least 2 months after the second dose and at least 4 months after the first.
- The third dose should *not* be given to infants under 6 months of age, because this could reduce long-term protection.

Adolescents 11 to 15 years of age may need only two doses of hepatitis B vaccine, separated by 4-6 months. Ask your health care provider for details.

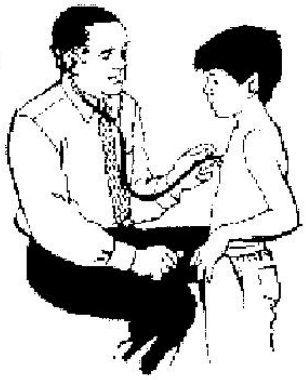
Hepatitis B vaccine may be given at the same time as other vaccines.

4 Some people should not get hepatitis B vaccine or should wait

People should not get hepatitis B vaccine if they have ever had a life-threatening allergic reaction to **baker's yeast** (the kind used for making bread) or to **a previous dose of hepatitis B vaccine**.

People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting hepatitis B vaccine.

Ask your doctor or nurse for more information.



5 What are the risks from hepatitis B vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of hepatitis B vaccine causing serious harm, or death, is extremely small.

Getting hepatitis B vaccine is much safer than getting hepatitis B disease.

Most people who get hepatitis B vaccine do not have any problems with it.

Mild problems

- soreness where the shot was given, lasting a day or two (up to 1 out of 11 children and adolescents, and about 1 out of 4 adults)
- mild to moderate fever (up to 1 out of 14 children and adolescents and 1 out of 100 adults)

Severe problems

- serious allergic reaction (very rare)

6 What if there is a moderate or severe reaction?

What should I look for?

Any unusual condition, such as a serious allergic reaction, high fever or unusual behavior. Serious allergic reactions are extremely rare with any vaccine. If one were to occur, it would be within a few minutes to a few hours after the shot. Signs can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967.

  VAERS does not provide medical advice

7 The National Vaccine Injury Compensation Program

In the rare event that you or your child has a serious reaction to a vaccine, a federal program has been created to help you pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit the program's website at **www.hrsa.gov/osp/vicp**

8 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department's immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (1-800-CDC-INFO) or **1-888-443-7232**
  - Visit the National Immunization Program's website at **www.cdc.gov/nip** or CDC's Division of Viral Hepatitis website at **www.cdc.gov/hepatitis**

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention
National Immunization Program

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Hepatitis B Declination Statement

Employee Name: _____

The following statement of declination of hepatitis B vaccination must be signed by an employee who chooses **not to accept** the vaccine. The statement can only be signed by the employee following appropriate training regarding hepatitis B, hepatitis B vaccination, the efficacy, safety, method of administration, and benefits of vaccination, and that the vaccine and vaccination are provided free of charge to the employee. The statement is not a waiver; employees can request and receive the hepatitis B vaccination at a later date if they remain occupationally at risk for hepatitis B.

Declination Statement

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature:_____ Date:_____

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A. PURPOSE: To provide a controlled substance, drug and alcohol-free workplace for the safety of all employees (leased, hired, or otherwise) and customers. In order to further this objective, the following rules governing alcohol and illegal drugs and inhalants in the workplace have been established.

B. POLICY: The illegal manufacture, distribution, dispensing, possession, sale, purchase, receipt or transmittal of controlled substances, or an attempt to any of the foregoing, while on Texas Care One Home Health Agency or Client Company's ("Company") property or on company related business is prohibited.

1. The unauthorized possession of alcohol or any alcoholic beverage on Company property or on Company related business is prohibited.
2. Being under the influence of alcohol or other illegal or intoxicating drugs or inhalants while on Company property or on Company related business is prohibited.
3. The unauthorized use or possession of prescription drugs or nonprescription over-the-counter drugs on Company property or Company related business is prohibited.
4. Employees who violate this policy will be subject to appropriate disciplinary actions, including termination.
5. This policy applies to all employees of the Company regardless of rank or position, and includes temporary and part-time employees.

C. TESTING: Testing of employees. All present employees (leased, hired or otherwise) will be requested to sign an Informed Consent and Release of Liability form. Employees may be tested for the presence of alcohol, drugs including inhalants and/or controlled substances in the event any of the following situations occur:

a. There exists a reasonable suspicion or belief that an employee is at work under the influence of drugs, alcohol, inhalant, or a controlled substance;'
b. There exists a reasonable suspicion or belief that drugs, alcohol, inhalants or a controlled substance are affecting an employee's job performance, attendance patterns, conduct, or safety of workplace actions;
c. The employee is suspected of having caused or contributed to an on-the-job accident;
d. When required by a customer or Company pursuant to the customer's drug testing policy. Such testing is not considered a Company drug test and may be subject to the customer's rules regarding drug tests.

1. Voluntary. In all instances, testing will be performed only with the applicant or employee's knowledge and consent. Refusal to submit to requested testing, however, may result in disciplinary action including termination of employment.
2. Company Testing. Urine specimens will be obtained at the Company's office, lab, testing facility; however, in the event of an accident or injury, samples may be obtained at an appropriate hospital, clinic, emergency room or doctor's office.
3. Test Results. A positive test shall mean the presence of alcohol, an inhalant or other drug or controlled substance has been found. An attempt by an employee to switch, adulterate, or tamper with any test result or sample submitted for medical testing, or otherwise interfere or attempt to interfere with the testing processes, shall result in immediate termination.

D. CONFIDENTIALITY: The Company shall make all reasonable attempts to keep the results of a positive drug test confidential. Such results shall be released to Company personnel only on a need-to-know basis. All positive written test results will be stored in a confidential file and be filed only by authorized Company personnel and kept only at the company.

E. DISCIPLINARY ACTION: Employees suspected of violating any of the policies contained herein may be suspended or removed from the workplace pending a complete investigation. Employees testing positive for drugs, alcohol, inhalants or other controlled substances will be subject to immediate discharge. Any employee who is otherwise found to have violated the policies herein will be subject to disciplinary action, including termination of employment. Should the determination be made that no violation of the policies contained herein have occurred, the employee will be reinstated without penalty.

F. EXCEPTION: An employee who possesses or uses a drug authorized by a licensed physician or medical practitioner through a prescription, specifically for the employee's use while on the job, and whose facilities are not noticeably impaired by the use of such drug, will not be considered to have violated this policy. Employees shall be responsible for discussing with the prescribing medical practitioner whether any prescribed drug will or may affect the employee's performance on the job. In the event an employee is advised that medication may affect performance, it is the employee's responsibility to notify his or her supervisor of the circumstances prior to reporting to work.

G. CONVICTION UNDER CRIMINAL DRUG STATUS: Every employee, as a condition of continued employment, is required to immediately notify the company if they are convicted under a federal or state criminal drug statute, whether the act giving rise to such conviction occurred on or off Company time or within or without the State of Texas.

H. COORDINATION WITH LAW ENFORCEMENT AGENCIES: The sale, use, purchase, transfer or possession of an illegal drug or drug paraphernalia is a violation of the law. The Company will report information concerning possession, distribution, or use of any illegal drugs to law enforcement officials and will turn over to the custody of law enforcement officials any such substances found during a search of an individual or property. The Company will cooperate fully in the prosecution and or conviction of any violation of the law.

Informed Consent and Release of Liability

I authorize Primecare Link Services LLC or Client Company ("Company") to obtain a specimen of my urine for chemical analysis. I understand that this analysis is to determine or exclude the presence of alcohol, drugs or other substances, in accordance with the Substance Abuse and drug Testing Policy of Company. I understand that decisions regarding my continued employment may be made as a result of this analysis. I understand that test results will be divulged only to authorized personnel. I hereby consent to this test and release Company from any liability for decisions resulting from this test.

Employee/Applicant Signature	Employee/Applicant Printed Name	Date

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Job Title: Personal Care Attendant (PCA)
Supervised by: Administrator

Revised: 12/02/2019

Job Summary: Performs duties essentially of supportive personal care, hygiene and related services to personal assistance clients in their homes or a home certified and authorized for personal care. Provide supportive and personal services for the clients with consideration of dignity and privacy.

Job Qualifications/Educational Requirements:

1. Graduate of an accredited High School or equivalent preferred.
2. Ability read, write and follow directions.
3. At least 18 years of age and has demonstrated competency.
4. Is under 18 years of age, is a high school graduate or is enrolled in a vocational educational program, and has demonstrated competency to perform the tasks assigned by the supervisor
5. Work positively and favorably with clients, families, and staff.
6. Demonstrate compassion, responsibility, and cheerful attitude.
7. Listed on the nurse aide registry with no finding against the aide relating to client abuse or neglect or misappropriation of client property.

Language Skills:

Ability to read and communicate effectively in English.

Physical Demands:

Prolonged standing and walking required. Ability to move up to 50lbs and move clients. Requires Working under stressful conditions to meet deadlines, to identify client needs, to make quick decisions and meet client/family psycho-social needs. Requires hand-eye coordination and manual dexterity. Ability to utilize durable medical equipment in the home. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions of the position without compromising client care.

Essential Functions:

- Performs duties as assigned by Administrator or Case Manager including baths, Oral hygiene, nail care, foot Care, skin Care, pressure relief, feeding and transferring client.
- Describes the activities of daily living and demonstrates the ability to use techniques to assist the client to meet these activities.
- Attempts in every possible way, to work with individuals and families, to assist them to assume responsibilities toward self-care. Helps the well family members to carry their share of the responsibilities and encourages the disabled/physically impaired member to participate in the life of the family, in so far as able.

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Care Plan:

Positions client in bed with proper body alignment.
Assists client with ambulation as necessary.
Performs all aspects of client care in an environment that optimizes client safety and reduces the likelihood of medical/health care errors.
Demonstrates the ability to draft and follow up client care plan and document according to professional standards.
Works as part of the interdisciplinary team.

Professional Requirements:

- Adheres to dress Code, appearance is neat and clean.
- Completes annual education requirements.
- Maintains regulatory requirements.
- Maintains client confidentiality at all times.
- Reports to work on time and as scheduled, completes work within designated time.
- Completes in-services and returns in a timely fashion.
- Attends annual review and department in-services, as scheduled.
- Represents the organization in a positive and professional manner.
- Actively participates in performance improvement and Continuous quality improvement (CQI) activities.
- Complies with all Organizational policies regarding ethical business practices.
- Communicates the mission, ethics and goals of the organization.
- Assists client with ambulation as necessary.
- Performs all aspects of client care in an environment that optimizes client safety and reduces the likelihood of medical/health care errors.
- Identifies and communicates findings to the Case Manager or Clinical Supervisor.
- Demonstrates the ability to chart according to professional Standards.
- Works as part of the interdisciplinary team.

The above list reflects the essential functions and other job functions considered necessary of the job identified, and shall not be construed as a detailed description of all work requirements that may be inherent in the job, or assigned by supervisory personnel. This job description is used as a guide only and not inclusive of responsibilities and job duties.

By my signature, I acknowledge that I have read and understand this job description and essential functions and its requirement. I understand and acknowledge that I am expected to complete all duties as assigned. I understand the job functions may be altered from time to time and that nothing contained in this job description may be construed as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily .

Employee Name Print: _____

Employee Signature: _____ Date: _____

Administrator/Supervisor Signature:_____ Date: _____

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Attendant Clock in and Out Policies and Procedures

Purpose: To outline the time clock policies and Procedures of Primecare Link Services LLC.

Part A: INTRODUCTION

Primecare Link Services LLC uses an electronic, cloud based time tracking system called DataLogic Vesta EVV clocking to capture and record all employee time records. Easy clocking collects actual time entered by the employee using the VisitClock. VisitClock is the interface that Primecare Link Services Employees will use to clock in and clock out from the Client's home. VisitClock encompasses the two methods of visit verification; Landline Phone and the Electronic Token, that is installed in the Client's home.

The VisitClock electronic time keeping system and associated work records is the official basis for recording hours worked for all employees of Primecare Link Services LLC. It also allows Primecare Link Services LLC to accurately monitor and keep track of the employee time and enables the Agency to efficiently process employee time worked for payroll purposes. Any disputes over actual hours worked or attendance will be resolved by referring to the VisitClock records.

Part B: Policies and Procedures

The following procedures and guidelines have been created to ensure accurate recordkeeping and compliance within Primecare Link Services LLC. In using the DataLogic Vesta EVV cloud based VisitClock time keeping system, the following regulations will apply:

1. Employees are required to clock in at their scheduled start time, and must clock out at their scheduled time out on the scheduled day of service.
2. Employees must clock in and out at the client's home where they access either the landline or the codes from the electronic token.
3. Employees are required to clock out any time they leave the work site for any reason other than assigned work duties.
4. Clocking in and out within the time-frame specified in items one (1), two (2) and three (3), will be calculated as an on-time report for duty and the time recorded will be the work-time paid .
5. In the event that clock in and clock out according to the planned schedule is not possible due to any given reason, the employee shall immediately inform Primecare Link Services LLC Supervisor or Administrator via Text message, email or by phone, detailing the developments surrounding the variation of clock in or clock out times.
6. Unless permission to do otherwise is authorized in writing by the employee's supervisor, no employee may exceed the number of client's authorized hours in any given week. Any adjustments to the recorded time must be approved by the employee's supervisor.
7. All variations in the scheduled times and adjustments to the recorded times will be verified with the client or the client representative by the Primecare Link Services LLC supervisor.
8. If an emergency circumstance arises and the employee is not able to report for work, the employee shall notify Primecare Link Services LLC supervisor by phone or text message within at least one hour of the scheduled clock in time.

9. If an emergency circumstance arises and the employee is not able to remain till the scheduled clock out time, the employee shall notify Primecare Link Services LLC supervisor by phone or text message within 15 to 30 minutes before they clock out to attend to the emergency or as soon as they clock out.
10. Under no circumstance may one employee clock in or out for another employee. Any employee participating in this type of violation will face immediate termination.

Violations of these procedures may result in disciplinary actions; including oral or written warnings, suspension without pay and/or termination. Any falsification or misrepresentation of time and attendance information may result in disciplinary action, up to and including termination.

Part C: VisitClock Instructions

a) VisitClock Landline Instructions

To use the landline clock in and clock out method, the agency will provide the employee with a toll free number to access the system. The employee will call the automated service that will prompt the employee through the steps needed to clock in and out with the employee EVV ID and Client EVV ID.

b) Clock In/Out Instructions:

1. At start of shift, the employee will call the given toll free number.

2. When prompted, enter the Employee EVV ID.

3. If prompted, enter the Individual EVV ID.

4. After receiving the call time, employee may end call.

The employee will repeat these steps at end of shift.

Part D: Policy and Procedure Agreement

I, _____have read, understood and agree to abide by the policies and
(please print)
procedures set forth by Primecare Link Services LLC, as precedent for the personal assistance service industry for compliance in providing care to Agency clients as designated.

I also understand that Primecare Link Services LLC Clock in and out Policy and Procedures are subject to review and update in line with local, state and federal procedures regulations.

Employee Signature: _____ Date: _____

Administrative Signature: _____ Date: _____

Primecare Link Services LLC

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Employee Conduct in the workplace

A. Expectations

Purpose: To outline the employee expectations while at work.

Policy: Employees are expected to abide by the following:

- Demonstrate good judgment, ethical personal behavior and common sense.
- Be at work and ready to work at the established starting time and are expected to remain at these positions and perform their assignments until the end of their shift.
- Perform all assigned duties, tasks and fulfill their responsibilities to Primecare Link Services LLC.
- *If possible work out a list of scheduled timetable for certain tasks, e.g. laundry, shopping etc.*
- Not to neglect their job duties or responsibilities, nor refuse any work assigned to them.
- Be available for work as scheduled or requested.
- Not to loiter or sleep while on duty.
- There is no time for watching television, videos or sitting to listen to the radio or music during the shift.
- Not misuse Primecare Link Services LLC client's time, belongings, and time for personal business or personal use.
    - *All employees are asked to make personal calls during short breaks and meal periods and to ensure that friends and family members are aware of this policy.*
- Not to solicit or accept gifts or tips from clients, their visitors or other employees.
- Not to take without permission , the client's belongings.

B. *Phone Calls, Texting, and Visitors*

Purpose: To outline the use of office telephones, personal cell phones at work.

- While at work employees must exercise discretion in using personal cell phones.
- Personal calls during the work hours, regardless of the phone used can interfere with employee productivity and be distracting. All employees are asked to make personal calls during breaks and meal periods and to ensure that friends and family members are aware of this policy.
- The Company will not be liable for the loss of personal cell phones brought into the workplace.

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I _____ I acknowledge receipt of Primecare Link Services LLC Employee Conduct Policies. I take note that the information, policies described in this booklet may be subject to change, I understand and agree that any such change can be made unilaterally by the company in its sole and absolute discretion, and that material changes will be made known to employees through the usual methods of communication within a reasonable period of time.

I agree to abide by the rules and the policies of this policies as follows:

(Initial all below)

1. ____Demonstrate good judgment, ethical personal behavior and common sense.

2. ____ Be at work and ready to work at the established starting time and are expected to remain at these positions and perform their assignments until the end of their shift.

3. ____ Perform all assigned duties, tasks and fulfill their responsibilities to Primecare Link Services LLC. If possible work out a list of scheduled timetable for certain tasks, e.g. laundry, shopping.

4. ____ Not to neglect their job duties or responsibilities, nor refuse any work assigned to them.

5. ____ To be available for work as scheduled or requested.

6. ____ Not to loiter, sit idle or sleep while on duty.

7. ____ Not to misuse Primecare Link Services LLC client's time, belongings, and time for personal business or personal use. This includes client's food staffs and other resources.

8. ____ Not to watch television, videos or sitting to listen to the radio or music during the shift.

9. ____ Not to solicit or accept gifts or tips from clients, their visitors or other employees.

10. ____ Not to take without permission , the client's belongings

11. ____ To exercise discretion in using personal cell phones, and make personal calls during breaks and meal periods and to ensure that friends and family members are aware of this policy.

12. _____ The Company will not be liable for the loss of personal cell phones and belongings brought into the workplace

13. _____ Failure to abide by the above rules and policies can lead to **disciplinary action**, **termination** and/or **prosecution.**

Name of Employee:_____

Signature of Employee: _____ Date : _____

Supervisor Signature: _____ Date _____

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INFORMATION RECEIVED	
Job Description	
Consent to perform Criminal Background check	
HIPPA (Confidentiality Agreement)	
New Hire Notice of Minimum wage	
Tuberculosis information	
Hepatitis B information	
Infection Control Guidelines	
How To Report Complaints	
Drug And Alcohol Policy	
Attendant Clock in and Out Policies and Procedures	
Policy and Procedure Agreement	
Payroll Schedule	
Employee Conduct	

Policy and Procedure Agreement

I, _____ have read, understand and agree to abide by the
(please print)
policies and procedures set forth by Primecare Link Services LLC.

I also understand that I may view or copy any or all of Primecare Link Services LLC policy and procedure manual for review or retention.

I also agree to adhere to all local, state and federal procedures regulated as precedent for the personal assistance service industry for compliance in providing care to Agency clients as designated.

Employee Signature: _____ Date: _____

Administrator/Supervisor Signature: _____ Date: _____