

STAFF INTAKE DOCUMENTS

All staff must have:

1. Valid Georgia Driver's License
2. Social Security Card
3. Valid CNA/PCA or LPN/ RN License
4. Valid CPR/First Aid
5. Valid TB skin test or chest x-ray with T-Spot
6. Must have a valid working phone number
7. Complete Background Check (INCULDING Fingerprint)

BLUE HORIZON TOTALCARE LLC.

APPLICATION FOR EMPLOYMENT

Please Print Legibly

Last Name	First Name	M.I.	Date
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PERSONAL INFORMATION

Current Address

City/State	Zip	Dates (From/To)
Home Phone	Cell Phone	Social Security Number

Previous Address (Last five years)

City/State	Zip	Dates (From/To)
Home Phone	Cell Phone	Social Security Number

POSITION OF INTEREST

HAVE YOU PREVIOUSLY SUBMITTED AN APPLICATION TO OR BEEN PREVIOUSLY EMPLOYED BY BLUE HORIZON TOTALCARE LLC? YES OR NO (circle one)

EDUCATION

School Name & Location	Years Completed	Course Major	Graduated (Yes or No)

LICENCES/CERTIFICATIONS

TYPE OF LICENSE/CERTIFICATION	EXPERIRATION DATE

BLUE HORIZON TOTALCARE LLC.

PAST EMPLOYMENT HISTORY

ACCOUNT FOR ALL TIME FOR AT LEAST THE PAST FIVE YEARS. INCLUDE PERIODS OF UNEMPLOYMENT OR SELF-EMPLOYMENT. GIVE COMPLETE ADDRESS, INCLUDING STREET, CITY, STATE, AND ZIP CODE. LIST MOST RECENT POSITION FIRST.

1.

Employer	Employed		Your Responsibilities
	From (month/year)	To (Month/Year)	
	Salary		
Address	<u>Start</u>	<u>Last</u>	
Position			
Name of Supervisor			
Reason for Leaving			

2.

Employer	Employed		Your Responsibilities
	From (month/year)	To (Month/Year)	
	Salary		
Address	<u>Start</u>	<u>Last</u>	
Position			
Name of Supervisor			
Reason for Leaving			

3.

Employer	Employed		Your Responsibilities
	From (month/year)	To (Month/Year)	
	Salary		
Address	<u>Start</u>	<u>Last</u>	
Position			
Name of Supervisor			
Reason for Leaving			

AUTHORIZATION AND ACKNOWLEDGEMENT

Please acknowledge your understanding and agreement to each of the following paragraphs by signing where indicated.

The information contained in this application is correct to the best of my knowledge. If I have falsified or omitted any information, regardless of the reason, any offer of employment may be rescinded, or my employment terminated.

The educational institutions, employers, and references listed on this application are authorized to give Blue Horizon TotalCare any information concerning my education and employment, any pertinent information they may have personal, or otherwise. I also release all persons or entities from liability for any damage that may result from Blue Horizon TotalCare reliance on the information furnished.

My employment by Blue Horizon TotalCare is contingent upon my provision of documents, required by law to show that I am a United States citizen, or an alien lawfully authorized to work in the United States.

Nothing contained in this application or in any other written material constitutes a contract between you and Blue Horizon TotalCare for employment for a fixed term in any other respect.

I further fully understand and agree that my employment with Blue Horizon TotalCare is at-will.

Print Your Name: _____

Signature: _____ **Date:** _____

BLUE HORIZON TOTALCARE LLC.

Emergency Information

Staff Name _____

Home Address _____

City _____ Zip _____

Home Phone _____

Family Members/ Emergency Contacts

Name: _____ Phone _____

Relationship _____

Name: _____ Phone _____

Relationship _____

Abuse Statement

I _____, have never been shown, by credible evidence (e.g. a court or jury, a department investigation, or other evidence), to have abused, neglected, sexually assaulted, exploited or deprived any person. I have never subjected any person to serious injury because of intentional or grossly neglecting misconduct as evidenced by an oral or written statement to this effect.

*****Any person found guilty of any of the above will not be hired by this agency. *****

Employee's Signature

Date

Blue Horizon TotalCare Representative

Date

BLUE HORIZON TOTALCARE LLC.

Code of Conduct

ALL EMPLOYEE/CONTRACTORS:

- Fulfills his/her confirmed schedule
- Arrives promptly for work
- Adheres to dress code policy (scrubs only). Remember appearance is very important
- Follows directions from supervisors
- Remains on assignment until relief arrives, unless otherwise stated by staffing coordinator.
- Notifies your supervisor of changes in patient's conditions. Be responsible and write down the name of the staff person to whom you speak.
- Exercise appropriate nursing skills (PCA to Sitters)
- Demonstrates concern for patient's safety and well being
- RN/LPN: accurately delivers medications. PCA/Sitter: understands they are not authorized to administer any medications.
- Documents information according to Healthsource Agency's charting guidelines
- Maintains current professional licenses, TB test, CPR certifications, and all other license and insurance as it pertains to your job description
- Remains alert and functioning while on duty
- Does not verbally, physically, or mentally abuse clients.
- Avoids abusing patient's hospitality (i.e. Client's telephone should be used only in an emergency or to call the office).
- Does not consume alcohol, drugs, or smoke while on duty.
- Does not accept or expect meals and/or gifts from client, client's family, and/or friends.
- Does not give personal home e=telephone number, beeper number and/or phone numbers to clients.

Possible reasons for permanent or temporary discontinuance of contract or employment:

- After three (3) unexcused call-outs, or cancellations, you will be placed on the inactive employees list.
- Repeated tardiness
- Constant no-call-no-show incidences
- Violation of dress code (scrubs ONLY)
- Refusal to accept directions or follow orders of your Supervisor
- Demonstrates lack of appropriate concern for patients safety and well being
- Failure to notify Nursing Supervisor of an changes in patients condition
- Leaving work before the end of a shift or before a replacement arrives
- Exercising inappropriate or poor nursing judgment
- Demonstrating lack of nursing skill as it relates to your Job Description.
- Failure to maintain current professional license, TB test, CPR certification or any other license or insurance, as it relates to your Job Description.

Code of Conduct continued next page.....

Code of Conduct continued

- Committing a medication error and/or omitting to report a medication error
- Sleeping while on duty
- Drinking alcohol or consuming other controlled substances while on duty
- Verbally, physically, or mentally abusing a client and/or any other inappropriate behavior
- Not following or adhering to policies, procedures, and duties as set forth the agency or the client. this includes but is not limited to breach of confidentiality
- Falsifying timesheets
- Accepting or taking gift from client, client's family and/or client's friends

Post Termination Employment

I agree that at no time during the period of this agreement, and for a period of two years (2) following the termination of this agreement that:

- I will not directly or indirectly engage any Agency clients who received services to me within the last 12 months to provide home care services, including without limitation, obtaining the services of the Agency client through any other provider.

This certifies that I have read and understand the above information.

Employee's Signature

Date

Blue Horizon TotalCare Representative

Date

Confidentiality Agreement for Employees

I, _____, as an employee of Blue Horizon TotalCare, I

understand that I must maintain strict confidentiality of client's information. In addition, I cannot disclose or cause to be disclosed any personal, financial, psychological, or medical information relating to a client except to appropriate staff, the client's representative, client's physicians, the Department of Human Resources, or other individuals authorized by the consumer in writing or, as may be required by the court subpoenas.

I understand that a breach of confidentiality may be interpreted as misconduct, if this is found; I may be disciplined and could result in the termination of my employment.

Employee's Signature

Date

Blue Horizon TotalCare Representative

Date

STAFF ORIENTATION DOCUMENTS & TOPICS

Print Name: _____

Please initial below and sign to confirm that orientation topics were reviewed and completed.

- ___ Policies and Procedures
- ___ Client Rights
- ___ The Handling of Complaints
- ___ TB, Hepatitis & COVID Exposure Reporting
- ___ Procedures for Reporting Client Progress & Problems to Supervisors
- ___ Procedures for handling emergencies
- ___ Review of Employee's job responsibilities

Employee's Signature

Date

Blue Horizon TotalCare Representative

Date

BLUE HORIZON TOTALCARE LLC.

Drug Testing

All job sites and the Blue Horizon TotalCare office are a Drug Free Environment. Blue Horizon TotalCare Services prohibits the possession, use, sale, distribution, or anyone being under the influence of alcohol and/or any illegal, unauthorized drug on company premises.

Random drug testing will be administered without notice. As an employee, you will be expected to respond within ninety (90) minutes of notification. Refusal to adhere to this policy will result in termination of your contract or employment with Blue Horizon TotalCare.

This policy is enforced in order to protect the safety and well-being of all contractors, employees, and the clients we serve. It is at the discretion of Blue Horizon TotalCare to continue to honor a contract with a person who has a positive drug screen.

A positive drug screen will be the responsibility of the employee-tested and the cost will be charged to that individual.

I acknowledge that I have been informed of Blue Horizon TotalCare. Drug and Alcohol Abuse Policy, including the fact that, as an Independent Contractor or Employee, I am subject to drug or alcohol testing. I understand that I will be released from my contract for refusing to be tested.

Print Name

Employee's Signature

Date

BLUE HORIZON TOTALCARE LLC.

Employee Health Screen

Name: _____

Date: _____

DOB: _____ Age: _____ Allergies: _____

Do you have any limitations that will limit you from performing the duties in which you have applied for? ____ Yes ____ No

If yes, please explain _____

Have you ever had, or have any of the following:

Asthma ____ High Blood Pressure ____ Heart Disease ____

Hepatitis ____ Cancer ____ Arthritis ____ Seizures ____

Diabetes ____ Tuberculosis ____ Hernia ____

Recurrent Colds ____ Communicable Diseases ____

Seasonal Allergies ____ Other (please list) _____

Height ____ Weight ____ Blood Pressure _____

Heart Rate _____ Temperature _____ Respirations _____

Any back injuries, herniated discs, or back problems in the last 10 years? ____ Yes ____ No

If yes, please explain: _____

Signature

NO MISCONDUCT STATEMENT

I _____ (Print name)

Never have been shown by credible evidence (e.g., a court or jury, a department investigation, or other reliable evidence) to have abused, neglected, sexually assaulted, exploited. Or deprived any person or to have subjected any person to serious injury as a result of intentional or grossly negligent misconduct as evidenced by a oral or written statement to this effect obtained at the time of application.

Signature _____ Date _____

Witness _____ Date _____

Blue Horizon TotalCare Representative

BLUE HORIZON TOTALCARE LLC

Policies and Procedures

ALL STAFF MEMBERS MUST CALL BLUE HORIZON TOTALCARE SERVICES OFFICE IF:

- You need time off for any reason. A 48-hour Advanced Notice is required for callouts and a two-week advanced notice is required for vacation time or leave request. Time off must be approved by the office and replacement coverage confirmed before leave is given.
- If you are unable to report to work, please contact the office IMMEDIATELY. It is not necessary for you to call the client, Blue Horizon TotalCare will contact the client.
- If you are experiencing any problems with an assigned client, please let Health Source Agency Inc. know and we will do all we can to formulate a solution.
- All changes in the clients' condition must be reported to the office immediately.

Frequent callouts will be noted and recorded in your employment record. Unexcused callouts can adversely affect your employment with Blue Horizon TotalCare.

All employees will be expected to work on public holidays (when it falls on your scheduled day of work).

Leave request for public holidays will require special approval by the office and must be applied for an official leave request form one month in advance. Approval will be granted on a first-time basis. When all alternative replacement employees (floats) are assigned, any leave request after that point will be denied.

All newly hired employees will be placed on probation for ninety (90) days. During this probationary period, attendance and general job performance will be monitored. You are expected to meet all requirements outlined during your orientation.

If all office lines are busy, you must leave a voice message and send text message. The office will return your calls as soon as possible. If you have any questions or concerns, Blue Horizon TotalCare staff is available to accommodate our employees and clients, Monday-Friday, 9am-5pm.

REMEMBER: Failure to report to scheduled assignments, or to notify the office of such incidents, is considered a NO-CALL-NO-SHOW infraction. You will be terminated automatically.

BLUE HORIZON TOTALCARE LLC

Doctor's Note Required:

A return slip is needed from your doctor if you:

- ✓ are involved in any type of accident
- ✓ incur injuries
- ✓ are admitted to the hospital
- ✓ are out sick due to the flu
- ✓ contract any contagious illness

Timesheets:

You are responsible for recording only the services rendered and the date and time that these services were performed on your timesheets. You must not record any time you did not work. This is considered FRAUD.

A timesheet is sent to you every pay-period along with your check. If you do not receive a paper check, timesheets are sent out with each monthly in-service. If you begin to run out of timesheets, feel free to make copies of your own. Otherwise, contact the office for additional timesheets.

ALL TIMESHEETS MUST BE FAXED, SEND VIA TEXT MESSAGE TO THE OFFICE ON THE MONDAY OF THE PAY WEEK. ALL ORIGINAL TIMESHEETS MUST BE TURN IN TO THE OFFICE BY WEDNESDAY OF THE PAY WEEK TO NOT PUT A HOLD ON YOUR CHECK. Timesheets must be

filled out with time, date, total hours, initiated tasks, and all required signatures. Incomplete timesheets will not be accepted. NO EXCEPTIONS. If this procedure is not adhered to, your paycheck cannot be guaranteed. We reserve the right to hold your paycheck for non-compliance to payroll policy. Please note that payday is every other Friday.

Thank you for your cooperation.

Employee's Signature

Date

BLUE HORIZON TOTALCARE LLC

Reporting Exposure to Tuberculosis/Hepatitis/HIV

CONTRACTOR OR EMPLOYEE: _____

Print Name

I, above named employee, have been informed to report all known exposure to blood borne pathogens Tuberculosis, Hepatitis, COVID and HIV to Mircale Home Care. I will report to my supervisor immediately and complete an employee incident report.

Employee Signature

Date

Blue Horizon TotalCare Representative

Date

BLUE HORIZON TOTALCARE LLC.

Title/Description: Administrator

Position Summary:

Accountable for the delivery of care to patients in the community. Collaborates with health professionals to facilitate quality care, and to support the concept of self-care. Direct staff involved in providing home care assuring daily continuity of care. Participates in health education, demonstrates leadership and communication skills. Ensure complaints are resolved timely and adequately along with QA systems.

Job duties include full authority and responsibility for the operation of Blue Horizon TotalCare:

The Administrator must be responsible for implementing and supervising the administrative policies of Blue Horizon TotalCare and administratively supervises the provision of all services. At a minimum, the Administrator must:

- a. Organize and direct the agency's on-going functions, ensuring that the agency is operating in a professional manner, to meet highest standards possible
- b. Assure that the documentation of services provided is accurate and timely
- c. Employ qualified, competent personnel
- d. Ensure adequate staff education and evaluation
- e. Ensure the accuracy of public information materials and activities
- f. Implement an effective budgeting and accounting system that promotes the health and safety of the agency's client
- g. Supervise and evaluate client satisfaction survey report on all clients served
- h. Ensure the agency adheres to the policies and procedures and operate in compliance with HFRD, DCH and other governing bodies including staff requirements

Qualifications

- a. Be a licensed physician, a registered nurse, Licensed social worker, licensed therapist, or Licensed nursing home administrator; or have a college degree
- b. Have at least a high school diploma or general equivalency degree
- c. (GED) (at minimum), training and experience in health service administration, and at least one year of supervisory or administrative experience in home health care or related health program. Other related health programs may include a hospital, nursing facility, or hospice, etc.

I have read this job description, and I can ____ (OR) cannot ____ meet the positions qualifications, performance requirements and essential job function.

Signature

Date

Blue Horizon TotalCare LLC Representative

Date

BLUE HORIZON TOTALCARE LLC.

Job Description - Nurse

Education and Training

Registered nurse or Licensed Practical Nurse with considerable administration and patient care experience, preferably 2-5 years. Graduate of an accredited program. Georgia License required.

Abilities

1. Emotional Stability
2. Ability to carry out and instruct others of M.D. orders
3. Diplomacy and tact
4. Intelligence
5. Make sound decisions and act quickly
6. Ability to work as a team member.
7. Good health and stamina
8. Tolerance and understanding
9. Good oral and written communication
10. Firm and perseverance pleasant leader

Responsibilities

1. Ensure basic mission of company through direct communication in patient care.
2. Plan and implement nursing care policies.
3. Manage personnel for patient care and promote good relations among employees.
4. Interview and hire as necessary to maintain correct patient staff ratio
5. Direct meetings periodically for efficient and effective maintenance of patient care.
6. Interpret Plan of Patient care and educate personnel for patient care and promote good relations among other employees.
7. Schedule staff and assist with care in emergencies and relief.
8. Establish effective communication with medical professionals and agencies.
9. Ensure client services through evaluation and problem-solving methods.
10. Supervising Registered Nurse.
11. Skilled nursing or other therapeutic services provided shall be under the supervision of a physician or a registered nurse.
12. The person shall be available at all times during operating hours and participate in all activities relevant to the professional services provided, including the developing of qualifications and assignments of personnel.

I have read the job description and _____ I can _____ I cannot meet the position's qualifications, performance requirements and essential job function.

Signature

Date_____

Job Description

Position:

Certified Nurse Assistant

Qualifications:

Training Requirements:

Present documentation of Nurse Aide Certification from the Department of Medical Assistance.

Position Qualifications:

18 years of age or older.

Be able to read and write; follow verbal and written instructions, and complete written reports of care given.

Must be able to communicate with the client.

Must be competent to perform the tasks assigned.

Evidence of sympathetic attitude toward care of the sick.

Annual completion of 8 CEU hours

Physical Requirements:

Visual/ hearing ability sufficient to comprehend written/ verbal communication. Ability to perform tasks involving physical activity, which may include heavy lifting and extensive bending and standing.

Duties & Responsibilities:

Performance Responsibilities and Standards:

1. Ensures quality and safe delivery of homecare services.
 - a. Participates in development and implementation of client Service Plan per agency policy and procedures.
 - b. Information regarding client Service Plan is submitted to the Nursing Supervisor in a timely manner.
 - d. Client clinical record documentation reflects delivery of quality and safe home care services.
 - e. Reports on the personal needs of the client
 - f. Reports on any change in the client condition and document and record

BLUE HORIZON TOTALCARE LLC.

- 2. Personal Care Services will only be performed by Certified Nurse Assist
 - b. Assists client with personal hygiene, grooming, and dressing.
 - c. Assists client with elimination.
 - d. Assists client with transfers and ambulation.
 - e. Escorts client to medical treatments and shopping.
 - f. Assists with food preparation, cutting up food and feeding.
 - g. Observes for changes in the clients' condition and report to RN
 - h. Assists with housekeeping tasks as assigned.
 - i. Assists with other activities of daily living.
 - j. Assists with laundry chores.
 - k. Assists clients with self-administered medications (i.e., read labels and remind them to take medications, provide glass of water, assist with opening medication containers).
 - l. Assists client with exercises.
 - m. Maintains record of care provided each day.
 - n. Service Plans are discussed with the Nursing Manger on a regular basis.
 - p. Infection control and safety policies and procedures are implemented per policy and procedure.
 - q. Identified client's needs are communicated to the Agency's Nurse Manager in a timely manner.
 - r. Clinical care is implemented per policies and procedures.
 - s. Client environment is neat and orderly.
 - t. Observations of client's conditions are accurately reported to the Nurse Manager in a timely manner.
 - u. Proper body mechanics are utilized consistently.
 - v. Obtain 8-hours of in-service training per calendar year.

Job Description Review:

I have read and understood the job description for the position of CNA.

CNA Signature **Date**

Administrator Signature **Date**

Employee's Withholding Certificate

Complete 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.

2024

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	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, and when to use the estimator at www.irs.gov/W4App.

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) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(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

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)
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ACKNOWLEDGEMENT OF APPLICANT'S NON-CRIMINAL JUSTICE
PRIVACY RIGHTS AND CONSENT TO BE INCLUDED
IN THE CAREGIVER PORTAL

SECTION I - PRIVACY RIGHTS - TO BE COMPLETED BY INDIVIDUAL BEING FINGERPRINTED:

- APPLICANT TYPE: [] Owner (Facility)
[] Applicant for Employment/Direct Access Employee (Facility)
[] Non-Employee (Facility Volunteer)
[] Contractor/Direct Access (Facility)

PRINT FULL NAME Last First Middle Date of Birth (mm/dd/yyyy)

Home Address Street City State Zip

Email Address Telephone No.

Name of Facility
Street City State Zip

I hereby authorize the Georgia Department of Community Health (DCH), Office of Inspector General, to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

Applicant Signature Date

SECTION II - CAREGIVER PORTAL - TO BE COMPLETED ONLY BY AN APPLICANT OR EMPLOYEE BEING FINGERPRINTED AS PART OF FACILITY LICENSURE. DOES NOT INCLUDE OWNERS OR FAMILY EMPLOYERS.

- APPLICANT TYPE [] Applicant for Employment/Direct Access Employee (Licensed Facility)
[] Non-Employee (Volunteer at Licensed Facility)
[] Contractor/Direct Access Employee (Licensed Facility)

The Georgia Caregiver Portal only contains the eligibility status of applicants and employees who have successfully passed the background screening process. The Caregiver Portal does not contain the names of applicants and employees who are ineligible.

- [] I agree to the results of my background check determination being available to family employers in the Georgia Caregiver Portal.
[] I am seeking employment only by licensed healthcare employers. I do not want or agree to the results of my background check determination being available to family employers.

Applicant Signature Date