Courageous Home Healthcare Inc. & Courageous Inc.
4339 Hartley Bridge Rd. Box 314
Macon, GA 31216
PH (478) 477-7594 Toll Free 877-227-3402
Fax (478) 477-2556 Toll Free 877-279-2131

You must get an official "OK" from the office only before starting work!
Failure to do so could result in a delay receiving your first Pay Check!
You are NOT working for/with Courageous Home Care until you have spoken with the Staffing Department at Courageous Home Care

Documents Below Required Before You Can Begin Working

	Item	Where To Get The Items	How Long it's Good For
1.	TB Skin Test / Chest X-Ray Results	Health Department or Doctor	Skin test =1yr Chest X-Ray = 3yrs
2.	CPR & Basic First Aid	Internet: simplecpr.com ($34.95) Red Cross / Fire Department Tech Schools / College	Simplecpr.com = 2yrs Red Cross = 1 – 3 yrs Others Vary
3.	CNA License	Tech School	Until Expiration Date
4.	Driver's License / Photo ID	Department of Motor Vehicles	Until Expiration Date
5.	Social Security Card	Social Security Administration	
6.	PCA License	Test Given by Company	Only while employed with the company
7.	Complete Application	Office	Must be turned in Before receiving first Check.

Application must be mailed to the above address. Please make a copy of the completed application before mailing in case the application gets lost in the mail. Please call the office to make sure all credentials and application have been received and processed. Failure to receive all credentials and application may result in a delay receiving your first paycheck. ***It is your responsibility to send and verify the receipt of your credentials and paperwork.***

Applicant Information Sheet

Please print or type all information. Make legible and clear.

Applicant Name: ____

SS#:____________________________ DOB: _________________ Age: _________________

Applicant Address: ____

City______________________ State _____ Zip _________ County________________________

HM Phone: (_____) _______-_____________ WK Phone: (_____) _______-_________

Cell Phone (_____) _______-_____________ Other (_____) _______-_____________

Email Address: ____

Emergency Contact Name: ____

Phone: (_______) _______-___________ Relationship: _______________________________

Client Hired to Work for: ____

First Date Worked: _________________________________

You must provide the office new contact information when a change is made.

____

(Below Line for Office Use Only)

Representative Signature: _____________________________________Date: ______________

Hire Date: ___________________________

CHH 09/2014

Five (5) Year Work History

List what you have been doing for the last five (5) years including schooling, employment gaps and must go back at least 5 years. Most recent first.

Start Date: ____/____/_____ End Date: ____/____/_____ Position Held: __________________

Employer: ____Phone: (____) _____-______

Address: ____

____

Reason for Leaving: ____

Start Date: ____/____/_____ End Date: ____/____/_____ Position Held: __________________

Employer: ____Phone: (____) _____-______

Address: ____

____

Reason for Leaving: ____

Start Date: ____/____/_____ End Date: ____/____/_____ Position Held: __________________

Employer: ____Phone: (____) _____-______

Address: ____

____

Reason for Leaving: ____

Start Date: ____/____/_____ End Date: ____/____/_____ Position Held: __________________

Employer: ____Phone: (____) _____-______

Address: ____

____

Reason for Leaving: ____

Start Date: ____/____/_____ End Date: ____/____/_____ Position Held: __________________

Employer: ____Phone: (____) _____-______

Address: ____

____

Reason for Leaving: ____

HIPPA Privacy and Security Policy Acknowledgement Form

This notice tells all applicants how and why personal information about applicants will be collected, how it will be handled and secured, and with whom the information is shared. We respect the privacy of personal information and maintain it securely according to the privacy and security rules under HIPPA. This notice applies to information regarding all current and former applicants.

Why we collect personal information:

- To determine eligibility for health care coverage.
- To transmit premium payments to the health insurance carrier.
- To provide test results to an officer of the company, government regulatory agencies, or companies that require certain tests under contract.
- For pre-employment physicals and to determine fitness-for-duty of the applicants job.
- To evaluate work-related injuries and comply with workers' compensation laws.
- To administer leave under FMLA (where applicable)
- To comply with OSHA, MSHA, and similar state laws.
- For judicial or administrative proceedings.

Personal Information we collect from applicants:

We ask people seeking employment and benefits to provide certain information when they begin employment and enroll in benefit plan. This information includes but is not limited to:

- Name, address, and phone number
- Social Security Number
- Birth Date
- Marital Status
- Information regarding current illness, injuries, or disabilities that may affect the ability to perform the job.
- Consent to release all applicable information, including physical exams, drug screening and fitness-for duty results to the company and its agents and service providers.

How we protect personal information under federal law:

Applicant's personal medical information is maintained in accordance with HIPAA and / or any other state or federal law to protect the privacy of such information. The confidentiality, integrity, and availability of any electronic protected health information (EPHI) will be ensured via appropriate safeguards as specified under HIPAA's security rule's effective date (4/21/2006 for small health plans; 4/21/2005 for all other covered entities).

How we protect personal information under state law:

Applicant's personal medical information is maintained in accordance with state law where such rules are more stringent than, but not contrary to HIPAA's privacy rule are preempted by the federal requirements, which means that the federal requirements will apply. The HIPPA privacy rule provides exceptions to the general rule of federal preemption for contrary state laws require certain health plan reporting, provide greater privacy protections, or provide for the reporting of disease or injury, child abuse, birth, or death.

If you want more information on HIPPA as it applies to your health information, please contact a representative of Courageous Home Care.

By signing this form, applicant has read and understands the policy of HIPPA.

____ ____________________

Applicant Signature Date

HIPAA Privacy Rule Applicant Confidentially Form

I, ____ have read and understand Courageous Home Healthcare Inc. or Courageous Inc.'s policies regarding the privacy of individually identifiable health information (PHI), as mandated by the Health Insurance Portability and Accountability Act of 1996(HIPAA) and the State of Georgia. In addition, I acknowledge that I have received training in Courageous Home Healthcare Inc. or Courageous Inc.'s policies concerning PHI use, disclosure, storage and destruction as required by HIPAA.

In consideration of my employment or compensation from Courageous Home Healthcare Inc. or Courageous Inc., I hereby agree that I will not at any time – either during my period of employment or association with Courageous Home Healthcare Inc. or Courageous Inc. or after my employment or association ends – use, access or disclose PHI to any person or entity, internally, or externally, except as is required and permitted in the course of my duties and responsibilities with Courageous Home Healthcare Inc. or Courageous Inc., as set forth in Courageous Home Healthcare Inc. or Courageous Inc.'s privacy policy and procedures or as permitted under HIPAA. I understand that this obligation extends to and PHI that I may acquire during the course of my employment or association with Courageous Home Healthcare Inc. or Courageous Inc., whether in oral, written or electronic form and regardless of the manner in which access was obtained.

I understand and acknowledge my responsibility to apply Courageous Home Healthcare Inc. or Courageous Inc.'s policies and procedures during the course of my employment or association. I also understand that unauthorized use or disclosure of PHI will result in disciplinary action, up to and including termination of employment or association with Courageous Home Healthcare Inc. or Courageous Inc. and the imposition of civil penalties and criminal penalties under the applicable federal and state law, as well as professional disciplinary action as appropriate.

I understand that this obligation will survive the termination of my employment or end of my association with Courageous Home Healthcare Inc. or Courageous Inc., regardless of the reason for such termination.

By signing this form, applicant has read and understands the policy of HIPPA.

____ ___________________

Applicant Signature Date

Name: ____
(Print)

Applicant Non-Disclosure Agreement

FOR GOOD CONSIDERATION, and in consideration of being employed by or associated with Courageous Home Healthcare Inc. or Courageous Inc., hereby and after referred to as the company, the undersigned applicant hereby agrees and acknowledges:

1. That during the course of my employment there may be disclosed to me certain trade secrets of the company or client, patient, and/or member; said trade secrets consisting but not necessarily limited to:

    a. Technical information: Methods, processes, formulas, compositions, systems, techniques, inventions, machines, computer programs, and research projects.
    b. Business information: Customer lists, pricing data sources of supply, financial data, marketing, production, or merchandising systems or plans.

2. I agree that I shall not during, or at any time after the termination of my employment or end of association with the company, use for myself or others, or disclose or divulge to others including future employers, trade secrets, confidential information, or any other proprietary data of the company in violation of this agreement.

3. That upon the termination of my employment or end of association with the company:
    a. I shall return to the company all documents and property of the company, including but not necessarily limited to: drawings, blueprints, reports, manuals, correspondence, customer lists, computer programs, and all other materials and all copies thereof relating in any way to the company's business, or in any way obtained by me during the course of employ. I further agree that I shall not retain any copies, notes or abstracts of the foregoing.
    b. The company may notify any future or prospective employer of the former employee or former associate of the existence of this agreement, and shall be entitled to full injunctive relief for any breach.
    c. This agreement shall be binding upon me and my personal representatives and successors in interest, and shall inure to the benefit of the company, its successors and assigns.

By signing this form, applicant has read and understands the Applicant Non-Disclosure Agreement.

____ ____________________

Applicant Signature Date

Code of Ethics

Caregivers <u>can do</u> the following:

* Assist with Eating
* Bathing
* Dressing
* Personal Hygiene
* Preparation of Meals
* Housekeeping Tasks
* Transfer Assistance
* Hair/Dental/Skin Care
* Condom Catheter Care
* Foley Catheter Care
* Activities of Daily Living
* Companion Sit

Caregivers <u>cannot do</u> the following <u>Without Office Approval</u>:

* Wound Care
* NG Tube Feeding
* Catheters
* Suppositories
* Prepare, Dispense, or Assist with Medication
* Bowel Programs
* Any Form of Nursing Services

Caregivers can NOT under any circumstances:

1. Use the member's care for personal reasons.
2. Consume the member's food or beverages.
3. Using member's telephone for personal calls.
4. Discuss political or religious beliefs, or personal problems with the member.
5. Accept gifts or financial gratuities (tips) from the member or member's representative.
6. Lend money or other items to the member; borrow money or other items from the member or member's representative.
7. Sell gifts, food, or other items to or for the member.
8. Purchase any items for the member unless directed in member's care plan.
9. Bring other visitors (e.g., children, friends, relatives, pets, etc.) to the member's home.
10. Smoke in the member's home.
11. Report for duty under the influence of alcoholic beverages or illegal substances.
12. Sleep in the member's home.
13. Remain in the member's home after services have been rendered.
14. Move in with member.
15. Bring children to work with them.

If you have any questions about the above information or if you need help determining approved tasks, please call the office for assistance. Our nurse can answer any questions about approved tasks.

By signing this form, applicant has read and understands What Caregivers Can and Cannot Do.

____ ____________________

Applicant Signature Date

Member's Rights & Responsibilities

1. The client has the right to be informed about the plan of service and to participate in the planning.
2. The client has the right to be promptly and fully informed of any changes in the plan of service.
3. The client has the right to accept or refuse service.
4. The client has the right to be fully informed of the charges for services.
5. The client has the right to be informed of the name, business telephone number, business address and how to contact the person supervising services.
6. The client has the right to be informed of the complaint procedures and the right to submit complaints without fear of discrimination or retaliation and to have complaints investigated by Courageous Home Care within a reasonable period of time.
7. The client has the right to have property and residence treated with respect.
8. The client has the right of confidentiality of client records.
9. The client has the right to receive a written notice of the address and telephone number of the state licensing authority, which further explains that the department is charged with the responsibility of licensing Courageous Home Care and investigating client complaints which appear to violate licensing regulations. Call or write: 1-800-878-6442 Healthcare Facility Regulation Division, 2 Peachtree St. N.W., Ste. 33.250 Atlanta, GA 30303.
10. The client has the right to obtain a copy of Courageous Home Care's most recently completed report of licensure inspection upon written request. (Courageous Home Care may charge the client a reasonable photocopying charge.)
11. The client is advised that the client and the responsible party, if applicable, must advise Courageous Home Care of any changes in the client's condition or any events that affect the client's service of needs.
12. The client has the right to present, either orally or in writing, complaints about services, and to have their complaints addressed and resolved as deemed appropriate by Courageous.
13. The client is advised that the client and the responsible party, if applicable, must advise Courageous immediately if a caregiver fails to arrive as scheduled to provide care.

By signing this form, applicant has read and understands the Member's Rights and Responsibilities.

____ ____________

Applicant Signature Date

Member Rights and Responsibilities

Member's rights include:

1. The right of access to accurate and easy-to-understand information.
2. The right to be treated with respect and to maintain one's dignity and individuality.
3. The right to voice grievances and complaints regarding treatment or care that is furnished, without fear of retaliation, discrimination, coercion, or reprisal.
4. The right of choice of an approved provider.
5. The right to accept or refuse services.
6. The right to be informed of and participate in preparing the care plan and any changes in the plan.
7. The right to be advised in advance of the provider(s) who will furnish care and the frequency and duration of visits ordered.
8. The right to confidential treatment of all information, including information in the member record.
9. The right to receive services in accordance with the current plan of care.
10. The right to be informed of the name, business telephone number and business address of the person/ agency supervising the services and how to contact that person/ agency.
11. The right to have property and place of residence treated with respect.
12. The right to review member's records on request.
13. The right to receive care and services without discrimination.

Member's Responsibilities include:

1. The responsibilities to notify case manager/ service provider(s) of any changes in care needs.
2. The responsibility to treat provider staff in a courteous and respectful manner, as well as cooperate with and respect the rights of the caregivers providing care.
3. The responsibility to be as accurate as possible when providing information on health history and personal care needs.
4. The responsibility to participate actively in decisions regarding individual health care and service/ care plan development.
5. The responsibility to comply with agreed upon care plans.
6. The responsibility to notify the member's physician, providers, and/ or caregiver of any change in one's condition.
7. The responsibility to maintain a safe home environment and to inform providers of the presence of any safety hazard in the home.
8. The responsibility to be available to provider staff at agreed upon times services are scheduled to be rendered.

By signing this form, applicant has read and understands the member rights and responsibilities.

______________________________ ____________

Applicant Signature Date

Member Abuse, Neglect, Exploitation and Resolution of Complaints

Policy

All individuals with a prior conviction on charges of abuse, neglect, mistreatment, or financial exploitation are prohibited from performing direct member care duties.

Procedure

All incidents of abuse, neglect, exploitation and or complaints submitted by client, caregiver or any responsible parties either orally or in writing will be documented in the complaint log book. All actions taken to resolve incident of abuse, neglect, exploitation and or complaints will be documented in complaint and resolution log book. A representative of Courageous will conduct a thorough investigation of all incidents of abuse, neglect, exploitation and or complaints submitted to Courageous in **WRITING**. Courageous will report to DCH/GHP within 24 hours of any abuse or alleged abuse. Courageous will complete an incident report (Appendix K-3) of the abuse or alleged abuse and submit the report to DCH/GHP within 5 days. A plan of correction will be submitted with the investigators report. A copy of the K-3 and plan of correction will be maintained in an accident and incident file for review by DCH. Courageous will take all steps to assure that no other incidents or abuse takes place while the investigation is ongoing.

Abuse, neglect of care or exploitation includes, but is not limited to:

A. Unauthorized or inappropriate touching of a member such as pushing, striking, slapping, pinching, beating, fondling, etc.
B. Use of physical or chemical restraints.
C. Withholding of food, water, or medications unless the member has requested the withholding.
D. Psychological or emotional abuse (i.e., verbal berating, harassment, intimidation, or threats of punishment or deprivation.
E. Isolating member from member representative, family, friends or activities.
F. Sexual harassment, exploitation or rape.
G. Failure to provide basic care or seek medical care.
H. Inadequate assistance with personal care, changing bed linen, laundry, etc.
I. Ostracizing the member, or “giving the silent treatment”.
J. Leaving member alone for long periods of time.
K. Taking a member’s money or property by force, threat, or deceit.
L. Use of member’s money or property against the member’s wishes or without the member’s knowledge.

By signing this form, applicant has read and understands the Member Abuse..

____ ____________________

Applicant Signature Date

Dress Code & Safety

Dress Code:

- Tennis Shoes – Rubber non-slip soles
- Professional Dress at all times (Scrubs unless client requests other)
- Cleanliness and Good Personal Hygiene
- Fingernails trimmed short and neat at all times.
- Minimal Jewelry

Safety:

- Keep walking area and area around the member's bed clear and free of any trip hazards including cords.
- Use legs to lift straight up. Do not lift with back bent.
- Immediately clean any spills/fluids off floor that can cause slip or injury.
- Wear gloves at all times.

By signing this form, applicant has read and understands the Dress Code.

____ _______________

Applicant Signature Date

Active Applicant Certificate of Agreement of Courageous Home Care's Policy & Procedure Handbook

I ____________________________________, have been provided a copy of Courageous Home Care's Policy and Procedure Handbook, I have also received the Substance Abuse and Testing Policy. I have read and understand that if my performance indicates it is necessary, or in the case of random testing, I will submit to a drug test. I also understand that failure to comply with the substance abuse test request or a positive result may lead to termination of employment or assignment and denial of unemployment benefits. I understand that failure to submit to a substance abuse test or a positive test result may affect my right to obtain worker's compensation benefits. I further agree to and hereby authorize the release of the results of said tests to the company. I have read and been given the opportunity to ask questions, and been given the answers to my questions about all material contained within this handbook for future reference and will advise office personnel if I should need another copy in the future. Nothing in this consent form is to be construed as a contract between the parties.

____ _________________

Applicant Signature Date

Courageous Signature Page

Responsibility to Report Known Exposure

As a part of the Courageous family, I understand that it is the applicant's responsibility and obligation to report any known exposures such as but not limited to: Tuberculosis and Hepatitis to Courageous immediately:

____ ________________
Applicant Signature Date

Evidence of Abuse

As applicant I understand that the Georgia Department of Community Health will not allow anyone who has 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 an oral or written statement to the effect obtained at the time of the application.

By signing this form, applicant states to have no evidence of Abuse in the applicants background.

____ ________________
Applicant Signature Date

Acknowledgement of Initial Orientation and Receipt of Courageous' Policy & Procedure Handbook

I, ____, as part of my initial orientation I have been provided a copy of Courageous' Policy and Procedure Handbook. I have read and been given the opportunity to ask questions about the content and materials contained within, and have my questions answered by Office Personnel. I fully understand all of the Policies and Procedures set in place by Courageous and agree to abide by these Policies and Procedures. I will retain a copy of this handbook for future reference and will advise office personnel if I should require another copy in the future.

I agree and understand that the purpose of this handbook is to inform me about the company's policies and procedures and nothing contained in this handbook constitutes an employment contract between the company and me.

I agree and understand that I am PRN (as needed), and as said PRN, I am not guaranteed any hours or days of employment, and my employment may be terminated, at any time, with or without cause and with or without notice at either my option or at the option of the company.

I understand and agree that the company reserves the right to modify or terminate any policies or procedures, in whole or in part, at any time, with or without notice. Since the information is subject to change, I acknowledge that revisions to the handbook may occur and it is my responsibility to view the most up to date handbook.

____ ________________
Applicant Signature Date

Applicant Direct Deposit Authorization

Applicant Name: ____

SS#: __________-__________-____________

I hereby authorize Courageous to initiate credit entries or such adjusting entries, either credit or debit which are necessary for corrections, to my account indicated below and the depository indicated below to credit or debit the same such account.

Applicant Name as appears on Account: ____

Bank Name: ____

Depository Account #: ____

Routing #: _______________________________________ Checking ___ Savings ___

This authority is to remain in full force and effect until Courageous has received written notification from me of its termination in such time and in such manner as to afford Courageous a reasonable opportunity to act on it. I understand that enrolling in direct deposit could take up to 2 weeks for processing and to go into effect.

*****Changes to this direct deposit will not be accepted by telephone; all changes must be put in writing, with the applicant's signature and faxed, emailed or mailed to the office. If changes are not received by the Monday prior to the Friday Payroll no changes will be made until the following payroll to allow for processing time.

<u>A direct deposit form from the bank or a voided check must be sent in with this authorization for each account or the authorization will be ineffective</u>. **No deposit slips will be accepted**.

If you currently do not have a checking or savings accounts please call BB&T Bank, this is our bank; they can work with you to set up a free At Work Checking or Savings account. Make sure that you tell them that you are an applicant of Courageous.

BB&T
(478) 538-0034
Toll Free 1-800-Bank-BBT

____ ____________________
Applicant Signature Date

Courageous

4339 Hartley Bridge Rd.
Box # 314
Macon, GA 31216
Phone: 478-477-7594 / 1-877-227-3402
Fax: 478-477-2556 / 1-877-279-2131
Email: courageoushomecare@gmail.com

Job Description

Personal support services perform personal care tasks such as, but not limited to, assistance with eating, bathing, dressing, personal hygiene, preparation of meals, housekeeping tasks, positioning, home management, home safety, sanitation, infectious control, taking of vital signs, proper nutrition and other activities of daily living as determined by appropriate staff. Personal support will be provided by staff that appropriately trained and/or certified.

For Caregivers Employed at:

- Assist with bathing
- Prepare Meals
- Wash Dishes
- Clean Bathroom
- Clean bedroom
- Change Linens
- Assist with dressing and undressing
- Housekeeping
- Run Errands
- Empty Trash
- Dust furniture
- Dressing
- Undressing
- Transferring

Caregiver Name: ____ Start Date: _______________

Supervisor Signature: ____________________________________ Date: ____________________

By signing this statement I certify that the Supervisor / Staffing Coordinator have gone over all of my above named duties. These are descriptive duties that are required of me to perform on my job at the above mentioned client's home.

Caregiver Signature: ______________________________________ Date: ____________________

<u>Procedure for Filling Out and Correcting Member Service Record Quiz</u>

*Member Service Records are considered "**Medical Records**" and are used to record the **dates and times** and employee works.

- Handwritten entries should be made with a **permanent blue or black** medium point pen.
- All entries must be **legible** to individuals other than the person making the entry
- If a mistake is made **DO NOT erase, scribble over, or use white out. Do not make any marks or notes anywhere other than what is required for you to make.**
- You must always **draw a line through the mistake put your initials beside every correction** you make.
- **Make sure that all dates and times you have worked are accurate** and always follow the **Client's care plan** as it is noted on your Member Service Record.
- Make sure you, the **caregiver, and the client** both sign your names at the bottom of each and every Member Service Record.
- You are to email/fax your Member Service Records into the office **every Thursday**, but the deadline is the next day, on **Friday by 5:00pm**.
- After you email/fax your Member Service Records it is important to call the office and verify that they have been received and also get your **confirmation number.**
- Examine your Member Service Records to make sure that all of your entries are **correct** before emailing/faxing them into the office, if it is not filled out correctly, a Payroll Specialist will contact you and have you fill out another one and email/fax it back.
- It is the **Caregiver's responsibility to email/fax in Member Service Records**, not the Clients.

Please remember that just because you get a confirmation report from the fax machine **does not mean that our office received it**, which is why you are to call and get your confirmation number. If your Member Service Records are received by our office after the deadline, you will be charged a **$25 processing fee** to have the Member Service Record processed for your payroll**.** It is vital that the **Payroll Department receives your Member Service Record(s) on time** to ensure that you receive a paycheck. If you encounter a problem while filling out your Member Service Records please contact the **Payroll Department.** Please note that the **State of Georgia** set forth these guidelines for how Member Service Records are to be filled out and we all must abide by their regulations at all times!

Name of Tester:____ 20______2HRS TESTING & TRAINING___________%

Member Service Record Quiz

1) Member Service Record(s) are considered ________________ ___________________.

2) Member Service Record(s) are used to record the ______________ and______________an employee works.

3) Handwritten entries must be made with a permanent______________or______________medium point pen.

4) All entries on the Member Service Record must be _________________________.

5) If a mistake is made on your Member Service Record you can use white out to correct the mistake.
   True False

6) Do not make any marks or notes anywhere other than what is required for you to make.
   True False

7) To correct an entry you should:
   A. Scribble over the mistake.
   B. Draw a line through the mistake and put your initials beside every correction.
   C. Use “white out” to cover the mistake and hope no one spots it.

8) It is important to make sure that all dates and times that you worked are accurate.
   True False

9) As the Caregiver you are to always follow the__________________as it is noted on your Member Service Record.

10) You, the ________________________ and the__________________both must sign your name at the bottom of each and every Member Service Record.

11) Your Member Service Record(s) are due in the office every_________________________.

12) The deadline for emailing/faxing your Member Service Record(s) into the office is on_____________by 5:00PM.

13) After emailing/faxing your Member Service Record(s) it is important to call the office to get your _____________________ number.

14) You are to examine your Member Service Record(s) to ensure that all of your entries are _______________________before faxing them into the office.

15) As a caregiver who is responsible for faxing the Member Service Records?
   The client
   Courageous Home Care Employees
   The Caregiver

16) Does getting a confirmation report from the fax machine confirm the office received your member service record?
   True False

17) If your Member Service Record(s) is received by our office after the deadline, you will be charged a $25 processing fee.
   True False

18) To ensure that you receive a paycheck, it is vital that the Payroll Department receives your Member Service Record(s) on time.
   True False

19) If you encounter a problem while filling out your Member Service Record, you should contact the Payroll Department.
   True False

20) The ___________ of _______________ set forth these guideline for how Member Service Records are to be filled out and we all must abide by their regulations at all time.

Signature of person taking the test:____Date_______________

Documented By:____________________________________Title: RN___LPN___Date:______Pass____Fail____

Post-Offer Medical Questionnaire

(To be maintained in a separate file of confidential medical records)

IF THERE IS ANY QUESTION OR STATEMENT ON THIS FORM THAT YOU DO NOT UNDERSTAND, ASK FOR ASSISTANCE FROM THE PERSON INTERVIEWING YOU.

Applicant Name: ____

Social Security # _________-_________-__________

Date of Birth ________/________/_______ Height _________ Weight _____________

By completing this form, I am verifying that the above named company has already presented a conditional job offer to me.

Check the following boxes where applicaple.

Have You Ever Had, Been Diagnosed With or Treated For?

Asthma

Migraine headaches

A head injury

A fear of heights

Heart trouble

Fainting spells or dizziness

Swelling of the legs or ankles

Skin rashes or Eczema

Joint pains or Arthritis

Epilepsy

Cancer

Varicose veins

Sickle cell anemia

Cardiovascular disorder

Tuberculosis

Mental retardation

Hemophilia

Chronic infection of bone

Ruptured disc

Depression

Tendonitis

Repetitive Motion Disorder

Stiffness of major weight-bearing joints

Kidney problems

Knee problems

Hay fever

Diabetes

Color blindness

Amputated limb

Loss of sight

Cerebral palsy

Multiple sclerosis

Parkinson’s disease

Back pain

Neck pain

Hand pain

Mental conditions

Muscular dystrophy

Nervous trouble

Do you need glasses to read or for distance?

Do you have partial loss of hearing?

Any serious wrist problems including Carpal Tunnel Syndrome?

Have you ever had an audiogram (hearing test) if yes, results_____________________________________

Any broken bones If yes, which bone(s) ________________ Where? __________________

High blood pressure? If yes, do you take medication to control high b.p.

Any serious injuries If yes, Month______ Year________ Nature of injury_________________

A hernia or rupture If yes, Month______ Year________

Any neck pain or problems If yes, Month_______Year________

Injured back If yes, Month_______Year________

Surgery If yes, Month_______Year________ Type________________________

Ever refused surgery If yes, why? ____

An allergic reaction to any drugs If yes, which drugs? ____

Partial loss of uncorrected vision of more than 75% bilaterally?

Psychoneurotic disability following confinement for treatment in a medical
or mental institution for a period in excess of six months?

Any permanent condition that constitutes 20% impairment of a foot, leg, hand,
or arm, or of the body as a whole?

Do you or have you participated in recreational drug use in the past year?

Have you ever participated in a drug abuse treatment program?
If yes where? ____

Do you currently take any prescription medications?
If yes, what? ____

Do you have any condition or have you sustained any injury that would have an effect on
your capacity to perform the duties of this position without reasonable accommodations?

Have you ever been hurt on the job or filed a worker's compensation claim in the past? if yes, How
many times? _________ What year(s)? __________________________

Please provide pertinent facts to every previous ailment or injury contributing to impairment, as well as all previous
worker's compensation claims in the space below:

____

____

____

Estimate the number of workdays you have lost in each of the past two years ______________________

Please list the name of any doctors you have seen during the past two years. List your family doctor first.

1.____

2.____

3.____

Check the following boxes where applicable

Have You Ever Been Refused Employment or Unable to Hold a Job Because of?

Sensitivity to dust

Inability to perform certain motions

Inability to assume certain positions

Other medical reasons?

If yes, please specify ____

****

OUR WORKER'S COMPENSATION INSURANCE CARRIER MAY CHECK FOR PREVIOUS CLAIMS BY NAME AND SOCIAL SECURITY NUMBER. IF YOU HAD A PREVIOUS CLAIM OR INJURY AND FAIL TO MAKE US AWARE OF IT, YOU MAY BE LEGALLY DENIED BENEFITS IN THE EVENT OF A NEW INJURY BY OPERATION OF THE LANDMARK RYCROFT RULING. FOR YOUR OWN PROTECTION AND FOR APPROPRIATE MEDICAL CARE, PLEASE MAKE US AWARE OF ANY PREVIOUS INJURIES.

****

____ __________________________

Signature of Applicant Date

____ __________________________

Company Representative Date

Contract of Services

Rev 9/2014

Agreement made this ____day of _______________, 20____, between ____
(month) (Print your Name)
hereinafter Subcontractor, I or me, and Courageous INC, hereinafter Company. The Contract of Services can be terminated at any time by either party with written notice. The parties to this agreement, in consideration of the mutual covenants stipulations set out, agree as follow:

I, ____, understand that the Company agrees to compensate me, the Subcontractor, for as long as I am a subcontractor, a rate to be set at the time of the signing of this contract and if I, the Subcontractor, decide to become an employee, I agree that my hourly rate of pay will be the amount set fourth at the signing of this contract.

I understand and agree to perform in accordance with all Conditions of Participation and to maintain all qualifications needed to provide the quality of care required by the Georgia Department of Community Health. I will be responsible for maintaining and providing the Company with proof of, but not limited to, current and up to date, CPR, BFA, TB Test, National background check and any annual training needed. The Company will inform me of any qualifications needed but not mentioned in this contract.

The Company will assume responsibility of finding a qualified subcontractor to complete the required job if the selected subcontractor fails to do so.

I understand that I will be responsible for my own insurance, worker's compensation, benefits such as vacation pay, holiday pay, overtime pay, estimated social security taxes, state, federal income taxes, and business license or other government registration typical of an independently established business.

I understand that the social security tax I must pay is higher than the social security tax I would pay if I were an employee.

I understand that the work is not covered by the unemployment compensations laws of Georgia and that I cannot claim unemployment benefits with this company.

I understand that by me signing this contract:

a. I promise that I do not receive more than 80% of my total income for personal services rendered from a single Company.

b. I am legitimately in business for myself and my income from other sources for personal services rendered now push the percentage of such income received from Company to fewer than 80% of my total annual income.

c. I perform professional services in the same occupation for clients, patients and customers other than the Company.

The Company will maintain responsibility for and assure the subcontractor's performance of administrative, supervisory, professional and service delivery responsibilities relative to and meeting all requirements of all Medicaid programs.

The Subcontractor will comply with local, state and federal laws, rules and regulations and will adhere to all Medicaid program's policy and procedures as they now exist or may hereafter be amended.

I understand that I will participate as needed in case conferences to coordinate member care.

I understand that at any time this contract can be terminated due to any Violation of the Georgia Department of Community Health Policies and Procedures. If the contract is terminated I will be contacted by the office and notified that my services will no longer be needed.

I understand that my hourly rate of pay as an employee is $7.25 and that my rate of compensation as a subcontractor is $_____ per unit. (*Any modifications i.e. marking thru, crossing out, or the use of white out of any part of this contract to include* ***rates of pay****, will in fact null & void the contract and possibly delay the application process, preventing you from being paid in a timely manner;* <u>*until*</u> *a new Contract of Services is filled out in its* <u>*entirety*</u> *and returned to the office.*)

I will provide ICWP _____ CCSP _____ Source _____ Personal Support Services.

Signature: ____ Date: _________________

Contract of Services

I understand that I am a Subcontractor and as a Subcontractor, I must maintain an office or shop of my own.

Signature: ____ Date: _______________

I understand that as a Subcontractor I must provide a National Background check prior to the start of contract unless I request that Courageous obtain one on my behalf for a fee of $35.00.

____ I have completed a National Background check within the past 30 days, from an acceptable source and have requested the original be mailed directly to Courageous at 4339 Hartley Bridge Rd #314 Macon, GA 31216.

OR

____ I am requesting that Courageous obtain a National Background check on my behalf for a fee of $35.00.

Signature: ____ Date: _______________

I do advertise and promote or otherwise hold myself out to the public as available to perform similar services.

Signature: ____ Date: _______________

I understand that I am contracted as PRN (as needed) and if my contract is terminated for any reason, I will not and cannot claim unemployment benefits with this company.

Signature: ____ Date: _______________

I understand that as a Subcontractor I am responsible for providing myself with my own worker's compensation insurance.

Signature: ____ Date: _______________

I understand that as a Subcontractor it is my responsibility to maintain and provide to the Company my CPR, Basic First Aid, TB test and annual training. I understand that if I fail to renew my certifications prior to expiration accordingly to the Policy & Procedure of the Healthcare Facility Regulation and the Georgia Department of Community Health I will not be qualified to receive compensation. This contract will be voided effective immediately upon expiration of any certification that is required of me to perform my services.

Signature: ____ Date: _______________

Contract of Services

Instrument as Entire Agreement

This instrument contains the entire agreement between the parties and no statements, promises, or inducements made by either party or agent of either party that are not contained in this contract shall be valid or binding. This contract may not be enlarged, modified, or altered in writing signed by both parties and endorsed on this agreement.

Effect of Agreement

This agreement shall inure to the benefit of and be binding on the heirs, executors, assignees, and successors of the respective parties.

IN WITNESS WHEREOF, the parties have executed this agreement on the day and year first above written.

________________________________	________________________________
Signature of Subcontractor	Signature of Courageous Representative
________________________________	________________________________
Print Name	Courageous Representative Print Name
________________________________	4339 Hartley Bridge Road Macon, GA 31216
Address	Address, City, State, and Zip Code
________________________________	________________________________
City, State, and Zip Code	Courageous Approval Date
________________________________	
Phone Number	
________________________________	
Social Security Number or FEIN Number	
________________________________	
Date of Birth	
________________________________	
Date	