

APPENDIX L - BLOODBORNE PATHOGENS - POST PROGRAM TEST

Take this test after reading the Bloodborne Pathogen In-service.

NAME: _____ DATE: _____

		True	False
1	HBV vaccinations increase the resistance level of the employee.	<input type="checkbox"/>	<input type="checkbox"/>
2	Gloves provide a barrier for a portal of entry.	<input type="checkbox"/>	<input type="checkbox"/>
3	A solution of one part bleach to four parts water can be used as a disinfectant.	<input type="checkbox"/>	<input type="checkbox"/>
4	Generally, all three doses of HBV vaccine are required to be taken to establish immunization.	<input type="checkbox"/>	<input type="checkbox"/>
5	It is required that needles be recapped before disposal.	<input type="checkbox"/>	<input type="checkbox"/>
6	Workers can reduce the dangers of contracting HBV through vaccination.	<input type="checkbox"/>	<input type="checkbox"/>
7	Healthcare workers must take special precautions only for patients who are infected with AIDS or Hepatitis.	<input type="checkbox"/>	<input type="checkbox"/>
8	Universal Precautions implies that you assume the blood and body fluids of ALL patients are infected with AIDS or Hepatitis.	<input type="checkbox"/>	<input type="checkbox"/>
9	Goggles and masks are worn whenever a risk of splashing or misting of blood is likely to occur.	<input type="checkbox"/>	<input type="checkbox"/>
10	There is no way to reduce the risk of contamination from blood and body fluids in the healthcare setting.	<input type="checkbox"/>	<input type="checkbox"/>

APPENDIX M

HIPAA-Health Insurance Portability and Accountability Act Review Quiz

Employee Name: _____ Date: _____

1. What does the HIPAA Privacy Rule do?
 - A. Impose new restrictions on the use and disclosure of personal health information
 - B. Gives patients greater access to their medical records
 - C. Gives patients greater protection of their medical records
 - D. All the above

2. A covered entity is a healthcare provider, health plan, a healthcare clearinghouse or a business associate who has access to patient records? True False

3. True or False: When a patient gives health information to a covered entity, that information becomes Protected Health Information (PHI). True False

4. True or False: In general, parents have the right to access and control the PHI of their minor children – except when state law overrides parental control. True False

5. What can you do to protect the patients privacy and confidentially?
 - A. Make sure you understand our privacy practices
 - B. Protect your patients' personal health information
 - C. Encourage others to do the same
 - D. All the above.



APPENDIX N – CONFIDENTIALITY AGREEMENT

The undersigned employee (“Employee”) of American Home Health (“the Company”) understands that Employee’s duties requires the Company has disclosed and will disclose to the Employee knowledge and information concerning its client’s/patient’s private information, business methods, and other means which constitute the property of the Company which enable the Company to operate successfully in its business. In disclosure of this confidential and proprietary information the Employee agrees as follows:

1. To hold in confidence any and all patient/client information for an indefinite period of time. Staff members may not discuss or communicate any medical record or client information except that which is necessary to perform their job.
2. To refrain from discussing clients/patients outside of the context of professional conversation regarding the patient’s/client’s condition or care.
3. To treat all matters relating to the Company’s business as confidential information, which has been entrusted to Employee solely for use of the Employee within the scope of their job with the Company.
4. Employee shall not, during the term of Employee’s employment, and for a period of one year thereafter, directly or indirectly divulge, communicate, furnish, make accessible to anyone or misuse in any way any knowledge or information of the Company with respect to a) any confidential information or trade secrets or business of the Company, b) patient/client lists, customer lists, or referral source lists or c) any patient list or any other information relating to patients/clients of the Company
5. Directly or indirectly request or advise any customer or client of the Company to withdraw, curtail or cancel any of their business or other relationships with the Company.
6. The Company shall be entitled to enforce this agreement by action brought in any court of competent jurisdiction for damages, injunctive relief or such other relief as may be appropriate under this confidentiality agreement. This agreement is legally binding on both of us and benefits our successors and assigns. The Company shall be entitled to all costs and attorneys fees incurred in enforcing this agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year written below.

Dated this _____ day of _____, 200__

Employee’s Signature _____

Witness’s Signature & Title _____



AMERICAN HOME HEALTH CORPORATION
1660 N. FARNSWORTH AVE., SUITE #3
AURORA, IL 60505
630-236-3501 (phone) 630-236-3505 (fax)

Attention _____ Facility _____

Applicant's Name _____ S.S.# _____

I hereby release from liability the company or person completing this form and authorize them to release all information regarding my employment with them.

Applicant's
Signature _____ Date _____

The individual above is applying for a position as _____ and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response. This information will be held in strict confidence.

1. Please confirm the applicant's dates of employment: _____
2. Please comment on the applicant's following attributes.

A. Quality of work _____

B. Knowledge and Practice _____

C. Reliability and Attendance _____

D. Cooperation _____

E. Competence _____

F. Supervisory Ability and Capacity _____

G. Personal Hygiene _____

H. Attitude _____

3. Please indicate specialty areas _____

4. Any special characteristics to be considered _____

5. Is applicant eligible for rehire? Yes _____ No _____

Signature _____ Date _____



APPENDIX O - EMPLOYEE HANDBOOK SIGN-OFF FOR AHHC

I have received the entire Employee Handbook and understand my responsibility to read the contents in its entirety. I agree to follow the official policies of the corporation to the best of my ability. I acknowledge that this handbook is a summary only of policies and the policies of the company can change without notice.

Initial _____

I understand that American Home Health has a drug and alcohol free policy. With this in mind I understand that I may be asked to undergo a drug or alcohol screen on a random basis. I further agree that in the event of an accident that occurs while I am on the job, I may be asked to undergo a drug and/or alcohol screen.

Initial _____

My beginning hourly rate will be: \$ _____

Visit Rates are discussed at time of orientation.

I authorize American Home Health Corp. to make investigative background inquiries in connection with my possible employment with AHHC. I understand that these background inquiries may include, but may not be limited to, consumer, criminal, driving, and other reports, and may include information regarding my character, work habits, performance, and experience, including reasons for termination. I understand, further, that AHHC may be requesting information from various federal, state, and other agencies that maintain records concerning my past activities relating to my driving, credit, criminal, and other experiences, as well as claims involving me in the files of insurance companies.

I authorize, without reservation, any part or agency contacted by this employer to furnish the above-mentioned information.

SIGNED _____ DATE _____

WITNESSED _____ DATE _____





FEE SCHEDULE FOR NURSES

Every effort will be made to schedule patients / visits close to your home within 20 mile radius.
Call in report to the report line or nursing supervisor. Must mail or drop off visit records weekly.

LEVEL 1 **Admission Nursing Visits**

Admission and Resumption of Care Visit

RN: \$65/Admission

RN: \$70/Weekend Admission

RN: \$55/Recertification or Resumption of Care Visit

RN: \$60/Weekend Recertification or Resumption of Care Visit

LEVEL 2 **Skilled Nursing Visits**

IV medication administration, TPN teaching, lab draws, assessment, wound care, IM / SQ injections, PICC or central line dressing change, etc

RN: \$45/visit

RN: \$50/Weekend Visit

LPN: \$35/visit

LEVEL 3 **Hourly Rate**

Visits requiring over 2 hours at the patient's home

RN: Paid at hourly rate*

LPN: Paid at hourly rate*

* Please note that you are going to be paid either using a fee or pre-determined rate or an hourly rate. If a visit goes over 2 hours, then you will be paid by the hour, NOT the normal rate plus the hourly rate.

Mileage: Mileage will be paid for visits over 20 miles from your home at \$.51/mile. Must be documented on time sheet.

Signature: _____ Date: _____