



1400 Coleman Avenue Suite G25
Santa Clara, CA 95050
Home Care Organization # 434-700-066
Toll-Free: 1 (855) 333-2559

Welcome to Ally Home Care & Medical Staffing!

Attached is the application packet which includes the employment agreement forms, time-sheet, and the employee handbook. Kindly read it carefully, fill out all the pages, sign, and date where appropriate.

When submitting the applications, please attach a copy of the following:

- Valid government issued ID (California ID or Driver's License)
- Proof of Residency (Permanent Resident Card, US Passport, or Proof of Citizenship)
- Social Security Card (SSN)
- Recent TB test or Chest X-Ray (2 Step PPD if required)
- Live Scan
- Home Care Aide Registration Number for Sitters/Caregivers

(Link <http://secure.dss.ca.gov/ccld/hcsregistry/registration.aspx?Action=New>)

- Current Professional License for CNAs, LVNs, & RNs
- Current CPR or BLS
- Drug Screening Result
- Flu Shot
- Physical Exam Result
- Voided Check for Direct Deposit
- Other in-service training certificates essential to the position

Please note that all health records must be within the year of the hiring date and out of pocket expenses.

Mail to: 1400 Coleman Avenue Suite G25, Santa Clara, Ca 95050

Fax to: (408) 564-4236

Email to: care@allyhomecare.net

Should you have any questions or concerns, please don't hesitate to contact the HR department at 1 (855) 333-2559 ext. 5. One again, thank you for your interest in Ally Home Care & Medical Staffing. We look forward to having you being a part of our team!

Sincerely,

Ally Home Care & Medical Staffing Management



1400 Coleman Avenue Suite G25, Santa Clara, CA 95050 1-855-333-2559

Home Care Organization # 434-700-066

APPLICATION FOR EMPLOYMENT

Date: _____ Date of Birth: _____
 Name: _____ SSN: _____
 Address: _____
 Tel. No.: _____ Cellphone No.: _____
 Country of Citizenship: _____ E-mail: _____
 INS Proof of Legal Right to work if not a U.S. Citizen: _____
 Do you drive? _____ (If Yes, please provide the following info)
 Driver's License No.: _____
 Car Insurance Carrier: _____
 Policy No.: _____

WORK HISTORY

1

Name and Address of Company	From	To

Name of Supervisor: _____ Tel. No.: _____
 Job Description: _____

2

Name and Address of Company	From	To

Name of Supervisor: _____ Tel. No.: _____
 Job Description: _____

3

Name and Address of Company	From	To

Name of Supervisor: _____ Tel. No.: _____

Job Description: _____

4

Name and Address of Company	From	To

Name of Supervisor: _____ Tel. No.: _____

Job Description: _____

REFERENCES

1. Name: _____ Tel. No.: _____

2. Name: _____ Tel. No.: _____

3. Name: _____ Tel. No.: _____

PERSONAL HISTORY

Can you work Live-in position hourly?

Do you smoke? Yes No

Do you drink alcohol? Yes No

Do you have allergies? Yes No

If so, what? _____

Have you been convicted of a felony? Yes No

Do you have physical limitations? Yes No

If so, what? _____

EMERGENCY CONTACT

In case of emergency, please notify:	
Name:	Relationship:
Address:	Tel. No.:

Authorization to Obtain and Disclose Information

I, _____, hereby authorize ALLY HOME CARE to contact my former employers and the personal references I have given with regard to my job performance and character. If this position requires either that I drive my employer's vehicle or drive the person I am caring for in my vehicle, I agree to show my employer proof of current insurance on my vehicle and proof of a valid driver's license. I also agree to cooperate with my employer in obtaining a copy of my driving record, with the understanding that my employer will pay any necessary costs. I understand that my employer may check public court records for cases, civil or criminal, listed under my name.

DAYS/HOURS AVAILABLE

Day of the Week	Beginning time of availability	Ending time of availability	Total number of hours
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

I attest to the best of my knowledge and belief that all above information is true and accurate:

Applicant's Signature

Date

Health Insurance Portability and Accountability Act (HIPAA)

What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996, (HIPAA), is the first comprehensive Federal law that provides consumers with privacy and security protection of their health information and their right to restrict the use and disclosure of this information. The privacy legislation was effective April 14, 2003. The security legislation is effective April 21, 2005. All organizations involved in providing health care services must comply with the privacy and security laws including health insurance companies, doctor's offices, pharmacies, hospitals, nursing homes, home care agencies, and any other locations that provide health care services.

What are some Examples of HIPAA violations?

- A celebrity was in the Medical Facility and you tried to sneak a peek at the paper or electronic record.
- You discussed patient information on an elevator, in a lobby, cafeteria, or other public locations, or to individuals not involved in the patient's care.
- One of your family members, neighbors, or friends is a patient and you kept others up to date on the events of his/her case.

What Can You Do?

Be mindful of ways to protect patient confidentiality and patient information, such as:

- Close patient room doors when discussing treatment plans
- Close curtains and speak very softly when in a semi-private room
- Never discuss patients or treatment in public areas (e.g. elevators, cafeteria)
- Never leave messages regarding patient conditions or test results on answering machines or with anyone other than the patient
- Never call/page patients in such a way as to reveal their health issues (e.g. "Patient Smith, please return to the dialysis unit")
- Never leave health information unattended in an area where others may inappropriately see and/or remove it
- Never leave a computer without signing off
- Never allow another person to use your computer after using your sign-on.
- Never share computer passwords with anyone
- Position computer screen so that visitors or people walking by cannot view information
- Require that a patient sign an Authorization to Release medical information form before provider copies of their health information. Requests for copies of records require a signed authorization placed in the patient record unless the record is needed for treatment by another healthcare provider. All legal requests for medical records (attorneys and subpoenas) should be referred to the Office of HIPAA Compliance.

Notice of Privacy Practices

Every patient treated must receive a written Notice of Privacy Practices. The notice is available in the Privacy Office and in every area where patients are registered to receive care. In the Notice of Privacy Practice, patients are advised of their rights. Some of these rights include the following:

- Receive a written notice of how Medical Facility uses their information including treatment, payment, and healthcare operations (e.g., quality assurance and patient satisfaction)

- Receive a copy of their health information
- Amend their health information
- Be informed of all recipients of their health information
- Restrict the use of their health information
- Request how their health information is used
- Complain about perceived violations of privacy

HIPAA Security

What is our Security Goal?

As mandated by HIPAA, our goal is to ensure confidentiality, integrity, and availability of all Electronic Patient Health Information (ePHI) so that it is not sabotaged, attacked, lost, stolen or misused.

What is ePHI?

Electronic Patient Health Information that can be linked to a specific individual's identity, medical condition, treatment or status as a patient.

How Can Security Fail?

Intentional "attack" (external – hacker or internal - employee)

- Malicious software (i.e. Virus, worm, Trojan-horse)
- Password stolen or code broken
- Imposter calling/e-mailing/instant messaging and asking for protected information
- USB drive / jump drive, or laptop stolen
- Employees accessing records they have no legitimate need to see

Employee carelessness

- Leaving your computer logged on, accessible and unattended
- Letting others know your password
- Downloading games or other unauthorized software
- Using instant messaging or chat rooms
- Misdirected e-mail/faxes

Whether it is an intentional attack or employee carelessness, the negative impact on the system is the same.

Faxing

Employees should take reasonable steps to ensure that fax transmissions are sent to and received by the intended recipient including:

- Ensuring that fax machines that receive confidential information are in a secure area
- Confirm intended recipient fax machine number or pre-program frequent recipients of confidential information
- Use 'confirm' receipt to verify that all faxed information was received by intended recipient

Electronic Mail (E-Mail)

- Confidential information may not be transmitted via electronic mail unencrypted unless there are no reasonable available alternatives for transmission
- Confidential information (including patient name or medical record number) may not appear in the header (subject line) of an e-mail message

- Subject line must make reference to the fact that the message contains confidential information
- HIV/AIDS, Mental Health or Substance Abuse patient information can never be included in an e-Mail

Action Steps to Take Every Day/Daily Reminders

Don't:

- Give anyone your password, ever, for any reason
- Download any software without first checking with IT
- Open any unknown web site or e-mail attachment
- Send patient information in e-mails going outside the network or in instant messages of any kind
- Leave your workstation without logging off your computer
- Give out patient data without proper authorization

Do:

- Choose a strong password (8 characters or longer, mix sets of characters) and change it when prompted
- Follow computer prompts to update virus scans when they appear on your computer screen
- Proof addresses when sending patient information
- Maintain heightened vigilance
- Follow all approved information security procedures
- Report anything that looks unusual

HIPAA regulations require that healthcare organizations have policies and procedures in place to protect patient's privacy and security. These policies stipulate how Medical Facility staff can use, disclose and dispose of health information.

Compliance with HIPAA regulations is a law but it is also an expectation of all employees including temporary employees.

HIPAA Orientation Acknowledgement

Please Remember...

- Be HIPAA Aware
- Think Patient Confidentiality
- Secure your own area
- Ask questions such as "Why do I need this information?"
- Help Educate Others

I will be responsible for my misuse, wrongful disclosure, and unauthorized access of confidential information. I understand that my failure to comply with the content of this document may result in the termination of my assignment including civil and legal liability.

Employee:
 Print Name: _____
 Signature: _____
 Date: ____/____/____

Employer:
 Print Name: _____
 Signature: _____
 Date: ____/____/____



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EMPLOYEE ACKNOWLEDGEMENT OF HANDBOOK

_____ (*Initials*) I hereby acknowledge receipt of **Ally Home Care & Medical Staffing** Employee Handbook. In consideration of my employment, I agree to read and abide by the rules and the policies of this handbook. Since the information, policies, and benefits 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 usual methods of communication within a reasonable period of time.

EMPLOYEE NAME: _____

DATE: ___/___/___

EMPLOYEE SIGNATURE: _____



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INFLUENZA IMMUNIZATION FORM

_____ (Initials) By signing my initials, I understand that attaching a copy of the influenza vaccination record is required at Ally Home Care & Medical Staffing. I have been instructed that as a result of this vaccination, I may experience some side effects such as:

1. SLIGHT DISCOMFORT
2. SORENESS OF THE ARM
3. REDNESS OF THE ARM
4. SLIGHT FEVER (OCCASIONALLY)
5. MUSCLE ACHES (OCCASIONALLY)

_____ (Initials) I hereby declined the administration of an Influenza vaccination and will abide by the regulation of the facility for declining. It includes but not limited to: Wearing a face mask at all times when working with the residents.

COMMENTS: _____

BENEFITS OF THE VACCINE

Influenza vaccine can prevent the influenza virus. Influenza can lead to pneumonia & can be dangerous for people with heart and breathing problems. Influenza kills about 36,000 people each year in the United States. Mostly among the elderly.

EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____ **DATE:** ____/____/____



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EMPLOYEE HEALTH QUESTIONNAIRE

Last Name: _____ First Name: _____ Middle: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Position Title: _____ Agency Name: _____

=====

Do you have a history of? (Mark Yes or No to the following conditions.)

- | | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO - Back Injury | <input type="checkbox"/> YES <input type="checkbox"/> NO - Asthma/Wheezing |
| <input type="checkbox"/> YES <input type="checkbox"/> NO - Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO - Drink Alcohol |
| <input type="checkbox"/> YES <input type="checkbox"/> NO - Have Allergies | <input type="checkbox"/> YES <input type="checkbox"/> NO - Skin Infections |
| <input type="checkbox"/> YES <input type="checkbox"/> NO - Pain/Stiffness Neck/Back | <input type="checkbox"/> YES <input type="checkbox"/> NO - Hernia |
| <input type="checkbox"/> YES <input type="checkbox"/> NO - High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO - Smoke |
| <input type="checkbox"/> YES <input type="checkbox"/> NO - Rashes | <input type="checkbox"/> YES <input type="checkbox"/> NO - Hospitalized |
| <input type="checkbox"/> YES <input type="checkbox"/> NO - Pain in Shoulders, Arms or hands | <input type="checkbox"/> YES <input type="checkbox"/> NO - Nervous/Mental Illness |
| <input type="checkbox"/> YES <input type="checkbox"/> NO - Pain in Hips, Knees or Ankles | <input type="checkbox"/> YES <input type="checkbox"/> NO - Operations |
| <input type="checkbox"/> YES <input type="checkbox"/> NO - Unusual weight gain or weight loss | <input type="checkbox"/> YES <input type="checkbox"/> NO - Accidents |
| <input type="checkbox"/> YES <input type="checkbox"/> NO - Eye Injury/Pain | <input type="checkbox"/> YES <input type="checkbox"/> NO - Ear Pain/Infection |
| <input type="checkbox"/> YES <input type="checkbox"/> NO - Tuberculosis Answer TB symptoms questionnaire | |

If you answer YES to any of the above, please explain below.

1. Are you familiar with your job duties and responsibilities? YES NO

2. Can you do the essentials of the job? YES NO

If you answer No, please explain _____

3. Have you ever been exposed and diagnosed with infectious disease? YES NO

If you answer YES, please explain _____

4. Are you currently taking any medications? YES NO

If you answer YES, please explain _____

5. State details of previous operations or illnesses. _____

6. Have you ever received any pension, insurance payments, or compensation for an injury of illness? YES NO

If you answer YES, please explain _____

Falsifying information on this form may be grounds for termination. Ally Home Care & Medical Staffing is dedicated to a policy of nondiscrimination in employment including age, gender, color, race, creed, nation origin, marital status, sexual orientation, political belief or disability.

Employee Signature: _____ Date: _____



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EMPLOYEE HEALTH EXAMINATION

Last Name: _____ First Name: _____ Middle: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Position Title: _____ SSN: _____ Date of Birth: _____

=====
Physician's Evaluation:

Blood Pressure: _____	Weight: _____	Ears: _____	Extremities: _____
Pulse: _____	Heart: _____	Nose: _____	Other: _____
Respiration: _____	Eyes: _____	Abdomen: _____	
Height: _____	Lungs: _____	Throat: _____	

I have examined _____, who is applying for or holds the positions of _____
_____. I have found no condition that appears to prevent him/her from performing the
essential function and other duties of the position applied for with the exception or the possible exception of
the following.

Further, I have found no indication of any condition which might represent a possible hazard to self, to the
health of residents, other associates, or visitors in the facility.

Physician Name: _____

Date: _____

Physician Signature: _____



TUBERCULOSIS SKIN TESTING FORM

SECTION I: INFORMATION/CONSENT

Mycobacterium tuberculosis (TB) is a disease which is carried through the air in small particles when people who have active TB cough, sneeze, speak, or sing. It usually affects the lungs but can also affect the heart, kidneys, bones, and other organs of the body. The TUBERCULOSIS SKIN TEST is a way of identifying TB infection. You cannot get TB from the skin test. Health care workers are required to be screened regularly for TB. **SIDE EFFECTS:** If you have been exposed to TB in the past, swelling and redness may develop at the site of the test. A blister or scar may also result. **PRECAUTIONS:** The TB skin test should not be given to persons who have had a positive reaction in the past, or who have had an active case of TB, or who have taken TB medications in the past. If this has happened to you, please tell the nurses prior to taking the skin test. Since there is no reliable method of distinguishing tuberculin reactions caused by BCG (bacille Calmette-Guerin) vaccine from those caused by natural infections, if you have received BCG vaccine (given in foreign countries) it is not a contraindication for receiving the TB skin test. The test should be given and interpreted routinely. Pregnant health care workers may receive the skin test. (Source: MMWR, Vol. 43/No. RR-13, CDC, 10/28/94.) Return to have your test read in 2-3 days (no less than 48hr; no greater than 72 hrs.) Failure to have the test read will necessitate repeating the test. If you have any questions or do not understand this information, please discuss this with the nurse now.

I have read and understand the above information on this form about tuberculosis skin testing. I give my consent to have the test.

Name (print): _____ Date: ____/____/____

Signature: _____

SECTION II: RISK ASSESSMENT Check

“Yes” or “No.” Please complete this section.

- | | |
|--|--|
| <input type="checkbox"/> YES/NO Have you ever had Tuberculosis? | _____ TB since your last TB test? |
| <input type="checkbox"/> YES/NO Have you ever had a positive reaction to a TB skin test? | <input type="checkbox"/> YES/NO A persistent cough for longer than 2 weeks |
| <input type="checkbox"/> YES/NO Have you ever had an allergic reaction to a TB skin test? | <input type="checkbox"/> YES/NO Loss of appetite |
| <input type="checkbox"/> YES/NO Have you ever been immunized against TB with BCG or other serum? | <input type="checkbox"/> YES/NO Coughing up blood |
| <input type="checkbox"/> YES/NO Have you had any type of vaccine within the past TWO weeks? | <input type="checkbox"/> YES/NO Unexplained weight loss |
| <input type="checkbox"/> YES/NO Have you taken steroids of any kind during the last 4 weeks? | <input type="checkbox"/> YES/NO Profuse night sweats |
| <input type="checkbox"/> YES/NO Have you had a known exposure to | <input type="checkbox"/> YES/NO Chills and/or fever |
| | <input type="checkbox"/> YES/NO Recurring, dull, tightness or aching pain in chest |
| | Date of last Chest X-Ray _____ |

TO THE BEST OF MY KNOWLEDGE, THE ABOVE ANSWERS ARE TRUE.

Employee Signature: _____ Date: _____

SECTION III: PPD ADMINISTRATION

Date given: ____/____/____
site: R/L forearm (circle)
2nd step Date given: ____/____/____
2nd step Site: R/L forearm (circle)

SECTION IV: INTERPRETATION

Date read: ____/____/____
Results in millimeters ____ induration
2nd step read: ____/____/____
2nd step in millimeters ____ induration

Nurse Signature: _____ Date: _____



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DRUG and/or ALCOHOL SCREENING CONSENT FORM

I hereby CONSENT to allow _____ [Testing Facility Name] to take a specimen of my urine or blood and submit it for a pre-employment or reasonable suspicion drug and/or alcohol test screen.

I further CONSENT to allow the laboratory testing service to make the results of each screen available to my prospective or current employer Ally Home Care and their human resources, safety or other business representatives or agents as needed. In consideration for such services being rendered on my behalf, I hereby RELEASE the laboratory testing service, its officers, agents, and employees, from any and all claims which I might otherwise have due to such results being made so available. I understand that a refusal to test where there is a reasonable suspicion may result in forfeiture of eligibility for benefits and potential disciplinary action up to and including termination. Applicants who refuse to cooperate in a drug test or who test positive will not be hired and will not be allowed to reapply/retest in the future.

I hereby CONSENT NOT TO FILE ANY ACTION at law or in equity against Ally Home Care, the laboratory testing service, their respective officers, agents or employees in connection with the results of such screening results being made so available. I further agree to INDEMNIFY and SAVE HARMLESS Ally Home Care, the laboratory testing service, their respective officers, agents and employees, from all damages, expenses, reasonable attorney's fees, and costs of court which they or any of them may suffer or incur, jointly or severally, due to the results of such screen being made so available.

Employee Signature: _____ Date: ____/____/____

Print Name: _____

Employee S/S.#: _____