

Homecare LLC

1370 Valley Vista Dr. Suite 200
Diamond Bar, CA 91765
Phone: 626-718-3851 Fax: 909 999 5910
Email: provider@providerhomecarellc.org
Director: Akunna Aniemeka

Application for Employment

(Please print legibly in Black)

Personal Information

Date: _____

First Name:	M.I	Last Name:
Home Address:		
City:	State:	Zip:
Home Phone ()	Mobile Phone ()	E-mail:
Are you authorized to work in the United States? Yes ___ No ___		
Have you ever been convicted of a Felony? Yes ___ No ___		
If Yes, explain:		
PLEASE NOTE: Answering yes will not necessarily disqualify you from employment with Homecare LLC		
Emergency Contact:		
Name:	Relationship:	
Home Phone:	Mobile Phone:	
Name:	Relationship:	
Home Phone:	Mobile Phone:	

Position(s) Applying For

(1) _____ (2) _____

Do you have experience in the position (s) you are applying for? YES () NO ()

THIS COMPANY IS AN EQUAL OPPORTUNITY EMPLOYER. WE CONSIDER ALL APPLICANTS FOR ALL POSITIONS WITHOUT REGARD TO RACE, COLOR, CREED, RELIGION, GENDER, SEXUAL ORIENTATION, NATIONAL ORIGIN, PREGNANCY, ANCESTRY, AGE, MARITAL STATUS, DISABILITY OR ANY OTHER DISCRIMINATORY CHARACTERISTICS PROHIBITED BY APPLICABLE STATE OR FEDERAL CIVIL RIGHTS LAWS.

*****INFORMATION PROVIDED IS CONFIDENTIAL*****

Education

High School: _____ Address: _____

Did you graduate? Yes () No () Degree: _____

College: _____ Address: _____

Did you graduate? Yes () No () Degree: _____

Other: _____ Address: _____

Did you graduate? Yes () No () Degree: _____

Previous Employment (list most current first)

Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Manager / Supervisor: _____

Job Title: _____

Responsibility: _____

Starting Salary: \$ _____ Ending Salary: \$ _____

From: _____ To: _____

Reason for leaving: _____

May we contact your pervious supervisor for a reference? Yes () No ()

Personal Reference

Name: _____ Relationship _____
Company: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
How long have you known the stated person? _____

Name: _____ Relationship _____
Company: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
How long have you known the stated person? _____

Training

Please inform us of training (s) you have obtained, or if this section does not pertain to you just skip it and go to the next section.

Name of facility: _____
Organizing Body: _____
Certificate obtained from training: _____
Date Issued: _____ Expiration Date: _____

Name of facility: _____
Organizing Body: _____
Certificate obtained from training: _____
Date Issued: _____ Expiration Date: _____
Areas of expertise? e.g., computers, children? _____

APPLICANT'S STATEMENT OF AUTHORIZATION

If I am hired, I agree to abide by all rules and policies currently in effect now or issued in the future. I understand that I can be terminated with or without cause/notice. I agree to have my picture taken for identification purposes and to submit to drug screening upon request. I authorize all previous employers to furnish my record. I hereby release them and Homecare LLC from all liability for any damage(s) whatsoever arising therefrom. I also authorize investigation of all statements in this application. I certify that my answers are true and complete to the best of my knowledge. I further understand that false or misleading information on this application may result in my release.

By signing this I verify that I have read the above statement, agreed and understood within the above parameters.

Signature: _____ Date: _____

Work Schedule Desired (Please check all that apply)

Sunday ()	Monday ()	Tuesday ()	Wednesday ()
Thursday ()	Friday ()	Saturday ()	Weekends ()
Fulltime ()	Part-Time ()	Days ()	Evening ()

Health Record

1. Have you had a TB Test or Chest X-Ray in the last six months? (You must submit record of a TB Test/ Negative Chest X-Ray within fifteen days of hire and every two years subsequently to work for this Agency).
2. Do you have current immunization records? Please check the records you have below and submit a copy (s) of the record (s) to the staff. Check N/A if you have your records on file or if what is stated does not apply to you.
3. Are you willing to take a drug test if required by a client? YES () NO ()
4. Have you had a physical within the past six months? YES () NO ()

If yes, can you provide us with the necessary documentation? YES () NO ()

If you answered no to question 3, are you willing to submit to a physical exam? YES () NO ()

CRIMINAL RECORD STATEMENT

A conviction is any plea of guilty or no contest or a declaration of guilt.

Have you ever been convicted of a felony? NO _____ YES _____

Have you ever been convicted of, or awaiting trial for any kind of abuse against minors?

NO () YES () if yes, explain _____

Have you ever been convicted of a felony in California? NO () YES ()

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California. You must disclose convictions, including reckless and drunk driving convictions even if

It happened a long time ago, Date: _____

It was only a misdemeanor; Yes _____ No _____

You must go to court? (Attorney went for you): _____

You had jail time? Or the sentence was only a fine or probation. _____

You received a certificate of rehabilitation. _____

The conviction was later dismissed, set aside or the sentence was suspended. _____

Have you been convicted of a felony? In Federal Court, In California or any other State? If so, provide the following information:

Which State and City? _____

When did this occur? _____

Tell us what happened. (Use additional sheets of paper if needed)_____

*Has your Professional License, if required for position, ever been revoked? NO _____ YES _____
If yes, please explain.*

_____ Declare under penalty of perjury under the laws of the State of California that all information contained in this affidavit are true and correct to the best of my knowledge and upon my signature all statements are certified as being true.

Signature: _____ Date: _____

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DRUG ABUSE POLICY

Homecare LLC strictly prohibits the possession, use and transfer of mind-altering drugs by employees at any time while present on Homecare LLC premises or while engaged in Homecare LLC business.

Homecare LLC employees must not report for duty, nor be present on clientele property, nor be engaged in Homecare LLC business, nor be in a motor vehicle owned, controlled, or otherwise in use for Homecare LLC business, while under the influence of, or in possession of any drugs other than those prescribed by a physician.

Patients or visitors may not possess, distribute and or use alcoholic beverages or controlled substances while on the premises of the property controlled by the Agency. Based on reasonable cause, the agency may conduct searches or inspections of an employee's personal belongings and may be asked to take a drug test. Refusal to consent may result in termination. Any employee who has knowledge of a person or persons violating this policy must report it to his/her supervisor immediately.

DEFINITION OF DRUG

For this policy, the term "DRUG" wherever it appears in this policy statement, includes all alcoholic beverages and all illegal drugs, including illegal inhalants.

CONSEQUENCES OF VIOLATION

At the sole discretion of Homecare LLC violation of any part of this Drug Abuse policy, will result in one or more of the following corrective actions: For Homecare LLC employees an oral or written warning, probation, suspension or immediate discharge. A full report of any violation and its corresponding corrective action will be documented and placed in the employee's permanent file. In determining corrective action, Homecare LLC providers will consider the severity of the violation, the past record of the employee, and the circumstances under which the violation occurred.

Name & Signature of Employee

Date

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EMPLOYEE COMPLAINT PROCEDURE

It is the desire of Homecare LLC to always maintain employee satisfaction. To minimize the possibility of misunderstanding, an employee is requested to discuss any problem or grievance with the employee's immediate supervisor as soon as possible after it arises. If the employee wishes to appeal the matter, such as disciplinary penalties or working conditions, the employee can formalize his/her complaint by following the grievance procedure outlined below:

Step One: Complete a Complaint Report Form and submit it to your supervisor.

Step Two: Discuss the problem with your supervisor.

Step Three: If the problem cannot be solved at the supervisory level, it should be discussed with the Chief Executing Officer.

The supervisor should document in the Complaint Report Form the action taken to resolve the employee's issue. A copy of the completed Report Form should be returned to the Chief Executive Officer.

As an employee/contractor of Homecare LLC or its subsidiaries, I have read and understand the above as it relates to complaints and their filing.

Employee's Name

Date

Signature

EMPLOYEE AGREEMENT AND CONSENT TO DRUG AND/OR ALCOHOL TESTING

I hereby agree, upon a request made under the drug/alcohol testing policy of Homecare LLC, to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis. I understand and agree that if at any time I refuse to submit to a drug or alcohol test under Agency policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate termination. I further authorize and give full permission to have the Agency send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Agency and/or to any clients that require proof of testing. Finally, I authorize the Agency to disclose any documentation relating to such to any clients that require proof of testing.

I understand that only duly-authorized Agency officers, employees, and agents will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make employment decisions and to respond to inquiries or notices from government entities.

I will hold harmless the Agency and any testing laboratory the Agency might use, meaning that I will not use or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug or alcohol test, even if a Agency or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless the Agency and any testing laboratory the Agency might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

I UNDERSTAND THAT THE AGENCY WILL REQUIRE A DRUG SCREEN AND/OR ALCOHOL TEST UNDER THIS POLICY WHENEVER I AM INVOLVED IN AN ON-THE-JOB ACCIDENT OR INJURY UNDER CIRCUMSTANCES THAT SUGGEST POSSIBLE INVOLVEMENT OR INFLUENCE OF DRUGS OR ALCOHOL IN THE ACCIDENT OR INJURY EVENT, AND I AGREE TO SUBMIT TO ANY SUCH TEST.

Signature of Employee

Date

Employee's Name - Printed

Agency Representative: _____ Date _____

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ADULT/ CHILD/ DISABLED ABUSE

Please read the following and then acknowledge that you have done so by signing this form in the space provided. The statement concerns your duty under the law to report instances of dependent adult abuse, child abuse and developmentally disabled abuse that come to your attention in your professional capacity. The Agency will be happy to provide you with more information about the reporting requirements and assist you in reporting any known abusive situation, should it be required.

California Welfare and Institutions Code Section 15632 requires Home Health Agencies to provide all dependent child/ adult care custodians and health practitioners who are employees after January 1, 1986, (both continuing and new employees), with the following statement. The legal definition of care custodian includes all employees of a hospital. California Law requires that this statement be signed as a prerequisite to employment by the home health agency.

In summary: Section 15630 of the Welfare and Institutions Code requires any child care custodian, health practitioner, or employee of an adult protective services agency of a local law enforcement agency who has knowledge of or observes a dependent adult in his or her professional capacity or within the scope of his or her employment who he or she knows has been the victim of physical abuse, or who has injuries under circumstances which are consistent with abuse where the dependent adult's statement indicate, or in the case of a person with developmental disabilities, where his or her statement or other collaborating evidence indicates that abuse had occurred, to report the known or suspected instance of physical abuse to adult protective services or a local law enforcement agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

In summary: Section 11166 of the Penal Code requires any childcare custodian, medical Practitioner, non-medical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment that he or she knows or reasonably suspects has been the victim of a child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

I understand the Dependent Adult Abuse and Child Abuse reporting requirements and will comply with them.

Name & Signature

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CONFIDENTIALITY AGREEMENT

The Agency acknowledges both a legal and ethical responsibility to protect the privacy of patients, clients, consumers and employees. Consequently, the indiscriminate or unauthorized review, use or disclosure of personal information, medical or otherwise, regarding any patient, client, consumer or employee is expressly prohibited. All information concerning patients, clients, consumers and employees should be held in the strictest confidence. Information contained in the records shall be disclosed only to professional persons providing the patient, client, consumer, or employee with services or referral; qualified professionals involved in conservation proceedings on behalf of the patient, client, consumer or resident; persons designated in writing by the patient, client, consumer, resident or by his/her parent (if he/she is a minor). Medical records and information regarding a patient's care may be read, shared, or discussed for reasons specific to the treatment plan of the patient and must involve only those individuals delivering or assessing the care of the patient, client, consumer or resident. Conversations regarding patients, clients, consumers or residents should be discreet and never held in public. Records may be copied only according to Agency policy and to comply with laws as outlined by the State of California and HIPAA as Protected Health Information. Except when required in the regular course of business, the discussion, use, transmission or in the narration of any patient, client, consumer, resident or employee information which is obtained in the regular course of employment is strictly forbidden. Refer to section 5328 of the California Welfare and Institutions Code.

All information that is gathered, maintained or stored by the agency becomes the agency's property and cannot be released without proper authorization from the administration. All proprietary information and all other confidential information relating to Homecare LLC and its affiliates must not be compromised, released, traded or disclosed.

Altering information is prohibited by the agency and by law. Correction of any identified erroneous information must be done according to agency policy.

In order to protect any individual from invasion of privacy and to protect the interest of the agency, any information gathered for patient care or operations will be gathered, maintained and stored in such a manner as to assure confidentiality.

Dissemination of information will be handled according to government laws and agency policy. Employess/Contractors will be informed during orientation, will sign the confidentiality statement and it will be placed in the employee's file.

My obligation to safeguard patient confidentiality continues after my termination of employment with Homecare LLC.

As an employee/contractor of Homecare LLC or its subsidiaries, I have read and understand the above as it relates to the confidentiality of records and information. I understand that for legal purposes, the Agency will take corrective action if there is any violation of this policy, therefore I will strictly adhere to the terms of this confidentiality agreement.

Name & Signature

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SUBMISSION OF DOCUMENTATION AGREEMENT

I agree that all documents (Time Sheets, Daily Communication Logs, Incident Reports, etc.) will be submitted within the following schedule, according to Agency policy:

1. Daily Communication Logs: By the Monday following the week of visit, (WEEKLY).
2. Weekly Timesheet: By the Monday following the week of visit, (WEEKLY).
3. Incident Reports: Within 24hrs of incident.
4. Health Screening/TB Test/Chest X-Ray: Within 15 days of hire and every 2years following hire date.
5. Address Change: Within one week of knowing of a change of address (Please notification is important as this will affect payroll and tax information delivery).
6. Closure Bank Direct Deposit /Change of Bank Account: Within one week of closing a Bank Account or changing any material information on Bank Account. (Please immediate notification is important as this will impact on your payroll and may cause you to incur fees).
7. Phone, Fax or mail upon receipt of a newly issued or renewed Driver's License/Identification, or changes showing new address or any other information.
8. Change of Name: As soon as legal documents to support change of name is received. (Please immediate notification is important as this will impact on your payroll and tax information).

Failure to comply with the above schedule will result in delayed payroll, employee suspension from duty, and /or re-assignment of visits to other employees for deadlines to be met.

I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.

Employee's Name & Signature

Date

Agency Representative

Date

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POLICY ON NON-DISCRIMINATION AND SEXUAL HARASSMENT

As a recipient of Federal financial assistance, HOMECARE LLC will not, directly or through contractual arrangements exclude nor discriminate against employees, contractors, clients nor patients in its admissions, employment, staff privileges or its provision of services and benefits, including assignments of transfers or referrals to or from the Agency, for any reason including race, creed, color, national origin, age, gender, religious belief, marital status, pregnancy, disability, sexual orientation or perceived sexual orientation, veteran status or any other consideration made unlawful by federal, state, or local laws. HOMECARE LLC is an equal opportunity provider and employer.

CIVIL RIGHTS

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at the Title 45 Code of Federal Regulations Parts 80, 84, 86 and 91.

Homecare LLC does not tolerate **Sexual Harassment**, as it is a form of gender-based discrimination.

Definition:

Under Title VII of the Civil Rights Act of 1964, any type of discrimination based on an individual's gender (male or female) is illegal. Sexual harassment is a form of gender discrimination. According to the Equal Employment Opportunity Commission, sexual harassment is "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submissions to the conduct enters into employment decisions and/or the conduct unreasonably interferes with an individual's work performance or creates an intimidating, hostile, or offensive working environment."

The Agency will not tolerate any form of sexual harassment from any of its employees, contractors or patients. The Agency encourages that any behavior which could be considered as sexual harassment be reported.

immediately to the supervisor and/ or Administrator. There is no need to fear retaliation. Both females and males can be sexually harassed when exposed to unwelcome sexual advances or to a pattern of verbal abuse, threatening, crude, impolite, or unprofessional conduct.

- Quid pro quo sexual harassment is also against company policy.
- The Agency encourages and urges an employee to come forward and discuss any sexual harassment that may have occurred with the Executive Director.
- Every complaint will be taken seriously and investigated immediately; Investigations will be documented.
- Any employee involved a sexual harassment complaint will have a full opportunity to give a full

Employee's Name & Signature

Date

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HEPATITIS B VACCINE CONSENT

Consent to administration of the hepatitis B vaccine. I understand that the Hepatitis B vaccine is available, at no cost, to employees whose jobs involve the risk of directly contacting blood or other potentially infectious materials. I have been informed of the method of administration, the risks, complications, and expected benefits of the vaccine.

HEPATITIS B VACCINE DECLINATION

HEREBY ACKNOWLEDGE that I have been informed of the availability of a Screening test for Hepatitis B surface antibody to determine whether I presently am immune to Hepatitis B. That test is performed on blood, which will be drawn from me and is at no cost, to employees whose jobs involve the risk of directly contacting blood or other potentially infectious materials.

I have also been informed that should it be determined that I am not immune to Hepatitis B, a vaccine is available which would decrease my chances of contracting Hepatitis B.

I understand that there are risks involved in performing the test to determine if I am immune to Hepatitis B. Those risks include, but are not necessarily limited to bleeding, injury from the needle to various structures surrounding the vein from which the blood will be drawn, including injury to nerve. Paresthesia, or numbness or tingling, or formation of a blood clot which could dislodge and enter my blood stream causing severe injury or death.

I also understand that there are risks attendant in receiving the vaccine against Hepatitis B. including but not necessarily limited to an adverse reaction to the vaccine which could cause anything from mild discomfort to severe injury or death caused by an anaphylactic or allergic reaction to the vaccine. In addition to all the above. I realize that there are also unknown, rare, unpredictable and unanticipated complications, which can possibly occur.

I understand that If I am not tested to determine whether I am immune from Hepatitis B, and/or if I am tested, and it is determined that I should receive the vaccine. I face the risk of being exposed to Hepatitis B germ and contracting Hepatitis B. I understand that if I contract Hepatitis B, I could suffer the following: pain, discomfort in suffering from the disease itself, permanent or temporary damage to my liver or other organs including my brain and heart, serious other disability, or death. In addition, I realize that there are also unknown, rare, unpredictable and unanticipated complications, which can occur because of contracting Hepatitis B.

I understand that I have the right to be informed of such risks and that I have the right to refuse both testing for immunity to Hepatitis B and the vaccine for it. And, if I refuse the testing or the vaccine at any time, I recognize that I may be reassigned to a position of lower exposure to the Hepatitis virus.

My signature below constitutes my acknowledgment:

1. That I have read, understood and agreed to the foregoing testing procedure and vaccination.
2. That the testing procedure and vaccination set forth above has been adequately explained to me and that I have received all the information I desire concerning such procedure and vaccination.

I HEREBY ACKNOWLEDGE that I have been informed of the availability of the above-testing procedure and vaccination for Hepatitis B, and have been advised that the testing procedure and vaccination is indicated for me because of the possibility that I may be exposed to Hepatitis B in the course and scope of my employment. I have also been advised as to the potentially dangerous risk and consequences of my failure to be tested and receive the vaccination at this time. Notwithstanding this advice, I hereby request that I not be tested for Hepatitis B and that the vaccine not be administered to me, and hereby release the agency, its personnel, the individuals who have advised me concerning the testing and vaccination program, from any responsibility whatsoever for un-favorable or harmful result caused by my refusal to permit the testing and/or vaccination for Hepatitis B.

Employee's Name & Signature

Date:

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OSHA BLOODBORNE PATHOGENS STANDARDS

Blood borne pathogens are microorganisms present in human blood that can cause disease in humans. These pathogens included Hepatitis B virus (HBV) and human immunodeficiency virus (HIV), Occupational transmission of HIV infection is somewhat more common, and the lethal nature of these diseases requires that we take reasonable measures to prevent exposure. The plan will include the identification of employees with occupational exposures, development and implementation of work practice controls, personal protective equipment, labels and signs, Hepatitis B vaccination and post-exposure follow-up and record keeping.

AREAS OF IMPLEMENTATION OF THE PLAN

- Written Exposure Control plan
- Initiate Information and Training
- Begin Required Record keeping.
- Hazards for Compliance (Including Hepatitis B vaccination)

EXPOSURE DETERMINATION

The standard, as outline above, identifies potential exposure hazards and describes methods of dealing with hazardous situations. The plan covers all employees who could reasonably anticipate occupational exposure by contact with blood or other potentially infectious materials because of performing their assigned duties. Within the Homecare LLC system, this would include all personnel assigned to the performance of cleaning services in accounts where blood and other infectious material might be associated with the customer's normal business operations, Each supervisor of employees is responsible for evaluating the nature of the environment where and employee will be performing their duties to determine which employees will receive the training, protective equipment, vaccinations and other provisions if an occupational exposure exists due to a reasonable anticipation skin, eye, mucous membrane of parental contact with blood or other potentially infectious materials.

- | | |
|---------------------------------|--------------------------------------|
| • General Medical Office | • Nursing Home |
| • Dental Office | • Drug Rehabilitation Center |
| • Mortuary or Funeral Home | • Abortion or Family Planning Clinic |
| • Health Care Provider | • Institutional Infirmary |
| • Blood Bank or Blood Treatment | |

Name & Signature

Date

Homecare LLC

AGENCY POLICY AGREEMENT

SAFE DRIVING STANDARD

The Agency's insurance carriers require all staff who drive automobile as an essential part of their daily duties meet reasonable safe driving standards. A DMV check is made on all new hires as a condition of employment and annually thereafter. Safe driving record standards during the past thirty-six (36) months is as follows: No more than three (3) moving violations; or no more than one chargeable accident; or no major charges such as reckless driving, driving while intoxicated/driving under the influence of drugs in the past five (5) years, etc. Staff whose driving record exceeds the above standards will be notified. Those individuals may be required to provide evidence of higher limits of auto liability insurance on their own vehicle.

If driving is an essential part of my job description, I understand that any employment is conditioned on a good DMV record. I authorize the company and/or its agents, including information-reporting bureaus (DMV) to verify any of this information. I authorize all former employers, persons, schools, companies and law enforcement authorities to release any information concerning my background and hereby release any said persons, schools, companies, law enforcement authorities and the Employment Agency from any liability for any damage whatsoever for issuing this information.

RESPONSIBILITY FOR ITEMS FURNISHED TO THE EMPLOYEE

In many positions throughout the Agency, company property is assigned for employees to use. These materials include but are not limited to address books, photocopies with names, addresses and telephone numbers of persons and/or facilities associated with the Agency, pagers, office keys, mobile phones, medical supplies, patient care equipment and office equipment. Any employee receiving such items will return them to the Agency in good condition, reasonable wear and tear accepted, at the termination of employment. If such item is not returned on time, the reasonable value of the item may be claimed against the employee and the employee agrees that its reasonable value may be deducted from his/her pay. The Agency assumes no responsibility for lost or stolen items of employees. Employees are encouraged to keep only "essential" items on their person, in the office or in the car.

CELLULAR PHONE USE

I understand that Homecare LLC does not permit employees on company time to talk or text using cellular phones while driving a vehicle. This is very dangerous and should be always avoided. It is mandatory that I must pull over and stop the vehicle each time I conduct agency business via a cellular phone.

The agency is not responsible for any moving violations, accidents or other incident that may occur while using a cellular phone and driving.

HEALTH SCREENING

If my job description includes direct patient care, I understand that any employment is conditioned on submission of a current (within 15 days of hire) written health assessment report which verifies that I am free from health conditions which would interfere with my ability to perform assigned duties. The report will also verify that I am free from signs or symptoms of infectious diseases. If employed, I agree to submit a medical examination at any time deemed appropriate by the Agency and as permitted by law.

RELEASE OF DOCUMENTS

I understand that the Agency may provide a copy of my Specialty License(s), CPR card, Health Screening, Immunizations, Vaccinations, Fire and Safety card, Driver's License, Academic Transcripts/Educational Qualification(s), and other personnel information, if requested, to authorize representatives of those organizations with which the Agency has contracts.

DISCLAIMER AND WAIVER OF LIABILITY

I acknowledge and will adhere to the rules and regulations as set forth by the California Department of Public Health and Medi-Cal. I understand that the falsification of documents, particularly those pertaining to the submission of Time Sheets, where in fact no visit was made, is considered to be fraud and is subject to filing of a criminal grievance, civil and/or criminal prosecution, and immediate termination. I, therefore, hold the Agency, its shareholders, directors and officers, harmless from any falsified documents.

ILLEGAL SOLICITATION AND REMUNERATION

Individuals employed by or under contract shall not willfully nor knowingly solicit, offer, receive or pay any remuneration including bribes, rebates or kickbacks directly or indirectly, overtly or covertly, in cash or in kind, in order to Clients whose care is reimbursed under any Federal or State Care Program.

HEALTH AND SAFETY AGREEMENT

I do understand the physical requirements of my job and understand proper lifting and moving techniques which I am expected to use in moving and lifting objects and/or patients. I have been informed and do fully understand that any injury claimed by me while on the job must be reported immediately to my supervisor and documented on an Accident/Incident Report form. I understand that unless an incident report is completed immediately and signed by me, the agency may not consider a voluntary payment of any medical bills or any other benefits as a result of my injury. I further understand that if the accident/injury is proven to be a result of my failing to follow policy/procedure, the agency may not be expected to cover medical payments. I do fully understand that I am not encouraged to lift or transfer any object or patient by myself unless I know that I can safely lift or transfer alone. If I believe there is no one readily available to assist me in lifting or moving patients or equipment while on duty, I am to wait until I can obtain assistance before moving or lifting.

INDEPENDENT CONTRACT

I understand and agree that nothing contained in this application, or conveyed during any interview, is intended to create an employment contract. I further understand and agree that if I am hired, my employment will be "at will" and without fixed term, and I may be terminated at any time, with or without cause and without prior notice, at the option of either myself or the Agency. No promises regarding employment have been made to me, and I understand that no such promise or guarantee is binding upon the Agency unless made in writing by the Executive Director. I will comply with all rules and policies of the Agency.

I understand that the Agency is a temporary employment agency and therefore does not guarantee full-time or part-time employment. Employment is on "as needed" basis.

I understand the Agency is an "At-Will" employer. This means that the Agency or I can sever the employment relationship at will, at any time with or without cause or advance notice. There are no expressed or implied commitments that in any way conflict with this right.

AGENCY FEE

I agree not to solicit the Agency's clients and attempt to manage and/or provide services at any time for these designated clients without prior written consent from the Agency. An employee who wishes to work privately for the Agency's clients shall pay an agency fee of \$5,000.00.

AGENCY HANDBOOK

I have received and read the contents of the current Agency Handbook. I understand that the contents of the aforementioned Handbook may be changed, altered, and otherwise modified at the discretion of the Agency. I agree to adhere to the policies enunciated therein.

ACKNOWLEDGEMENT (please read carefully)

I have been formally instructed on the policies and procedures of HOMECARE LLC. I understand the general policies and conditions of employment and agree to abide by them throughout employment with the agency.

I have been formally instructed in maintaining the confidentiality of the medical records and I understand that the medical information regarding the patient may not be discussed with anyone, either inside or outside the agency, unless a release of information form has been completed and signed by the patient. It is my understanding that such discussion or release of information is cause for dismissal.

I have been instructed on Disabled/Elderly Abuse Reporting, Dress Code and Professional Code of Conduct.

Regulations require that all employees have a physical examination and a chest x-ray within 14 days of their date of employment. Failure to comply with these regulations may result in the termination of Employment.

I have attended a formal orientation and have read and signed a job description for my specific classification. I understand that there is a Ninety (90) day probationary period.

I further assert that I have no injuries or disabilities or health conditions that will hinder me from performing my duties (which may include strenuous physical activities, lifting, bending, and prolonged standing, or walking).

Homecare LLC agency is not responsible for my transportation problems. If I do not have a car, the agency cannot guarantee work close to my home or within walking distance or on a bus line. Although the agency will try to do everything possible, transportation remains my responsibility.

The Management of Homecare LLC reserves the right to the following:

- Add work rules or standards of conduct as it deems necessary.
- The right to manage Homecare LLC.
- The rights to modify, add, delete or change any portion of the booklet. If this should occur; you will be advised in writing.

PAY PERIOD IS BI-MONTHLY

By signing this application, I hereby certify that the information contained in this application form and in any attachments listed below (hereafter made a part of this application) is true and correct to the best of my knowledge and agree to have any of the statements checked by the organization unless I have indicated to the contrary. I authorize the references listed above to provide the company all information concerning my previous employment and any pertinent information that they may have. Further, I release all parties and persons from all liability for any damages that may result from furnishing such information to the company as well as from the use or disclosure of such information by the organization or any of its agents, employees, or representatives. I understand that any misrepresentation, falsification, or material omission of information on this application may result in my failure to receive an offer or, if I am hired, in my dismissal from employment.

I have read the above and fully understand these requirements. I agree to abide by the policies, regulations and requirements of Homecare LLC.

Employee's Name & Signature

Date

Homecare LLC

1370 Valley Vista Dr. Suite 200
Diamond Bar, CA 91765
Phone: 626-718-3851 Fax: 909 999 5910
Email: provider@providerhomecarellc.org

Incident Report

The information below will help all employees to act when an incident, the passing of a client, occurs.

EMPLOYEE REPORT PROCEDURE

Special incident report (SIR) must be reported to Homecare LLC

- **Verbal Report within 24 hours of the incident.** Employees should make a call to the Agency associated with the client. Please provide Clients full name, sex, date and time of the incident. Description of the incident and your name.
- **Written (typed) Report.** A written report must be submitted within 48 hours of the incident via email.

Name

Signature

Date

Homecare LLC

1370 Valley Vista Dr. Suite 200

Diamond Bar, CA 91765

Phone: 626-718-3851 Fax: 909 999 5910

Email: provider@providerhomecarellc.org

Director: Akunna Aniemeka

RELEASE OF LIABILITY RE: PERSONAL VEHICLE USE

Homecare LLC has informed me that under no circumstances am I authorized to transport any client that is in my care, in my personal vehicle. I have been informed that while taking care of any Homecare LLC client, Public transportation is the recognized mode of travel.

If I decide to transport the client or use my personal car to attend to any client's needs, I acknowledge that Homecare LLC will not be liable for any injuries or damages incurred.

_____, hereby release Homecare LLC from
Any liability incurred on me and/or my vehicle if I use my personal care for the needs of any client.

Employee's 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.

2026**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) ☐ Single or Married filing separately ☐ Married filing jointly or Qualifying surviving spouse ☐ 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.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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 the 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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):

(a) Multiply the number of qualifying children under age 17 by \$2,200

3(a) \$

(b) Multiply the number of other dependents by \$500

3(b) \$

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here

3 \$**Step 4:
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.** Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here**4(b)** \$(c) **Extra withholding.** Enter any additional tax you want withheld each pay period**4(c)** \$**Exempt from
withholding**I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 ☐**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
employmentEmployer identification
number (EIN)



Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in Section 1, or specify which acceptable documentation employees must present for Section 2 or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employers must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct. Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.): ☐ 1. A citizen of the United States ☐ 2. A noncitizen national of the United States (See Instructions.) ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.) ☐ 4. A noncitizen (other than Item Number 2. and 3. above) authorized to work until (exp. date, if any) If you check Item Number 4., enter one of these: USCIS A-Number OR Form I-94 Admission Number OR Foreign Passport Number and Country of Issuance						
Signature of Employee				Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment. You must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

List A	OR	List B	AND	List C	
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
☐ Check here if you used an alternative procedure authorized by DHS to examine documents.					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					
Last Name, First Name and Title of Employer or Authorized Representative				Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code			

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Authorization For Direct Deposit

I authorize _____ to deposit my pay automatically to the account (s) indicated below and, if necessary, to adjust or reverse a deposit for any payroll entry made to my account in error. This authorization will remain in effect until I cancel it in writing and in such time as to afford _____ a reasonable opportunity to act on it.

Name on the account: _____

Bank account number _____ Checking _____ Savings _____

Bank routing number _____

Amount \$ _____ or entire paycheck _____

***Balance of pay to:**

_____ Manual (paper check)

_____ Account described below

***Note:** Split payments are not available for contractors.

Name on the account: _____

Bank account number: _____ Checking _____ Savings _____

Bank routing number: _____

Important: Please attach a voided check for each bank account of which funds should be deposited.

Employee/Contractor signature _____

Date _____

Payers: Do not send this form with your Direct Deposit enrollment. Keep your records.

HEMOCARE LLC

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Diamond Bar, CA 91765
Phone: 626-718-3851 Fax: 909 999-5910
Email: provider@providerhomecarellc.org

JOB ACCEPTANCE

I have received the applicable job description(s), I hereby accept the job.

I have read and consented to comply with the Agency's policies and procedures.

I further understand and agree that my employment/contract is "At Will" and without fixed terms, that I may be terminated at any time, with or without prior notice, at the option of either myself or the Agency.

No promises regarding employment have been made to me and I understand that no such promise or guarantee is binding upon the Agency unless made in writing by the Executive Director of the Agency.

Employee's Name & Signature

Date

Agency Representative's Name & Signature

Date

HEMOCARE LLC

1370 Valley Vista Dr. Suite 200
Diamond Bar, CA 91765
Phone: 626-718-3851 Fax: 909 999-5910
Email: provider@providerhomecarellc.org

CalSaver Retirement Plan

Homecare LLC is required by California Statelaw to offer employees a retirement plan. The CalSavers Retirement Savings Program was created by state law to ensure all California workers can save for retirement through automatic payroll contributions facilitated from their workplace.

It can be transferred from one job to another. It is a Retirement plan designated with you in mind.

When you save with CalSavers, you will put your money into work for you.

You have access to your savings at any time, and the savings in your account is always yours.

If you would wish to participate in the program, please check ()

If you would like to opt out of the program, please check ()

You can find out more information at www.calsavers.com

Employee's Signature

Date



[Print Form](#) [Reset Form](#)
REQUEST FOR LIVE SCAN SERVICE
(Custodian of Records)

Applicant Submission

CA0349400

ORI (Code assigned by DOJ)

CUSTODIAN OF RECORDS

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

CUSTDN RECORDS 11102.2 PC

Authorized Applicant Type

Contributing Agency Information:

DEPARTMENT OF JUSTICE

Agency Authorized to Receive Criminal Record Information

P.O. Box 903417

Street Address or P.O. Box

SACRAMENTO

City

CA 94203-4170

State ZIP Code

15798

Mail Code (five-digit code assigned by DOJ)

Contact Name (mandatory for all school submissions)

Contact Telephone Number

Applicant Information:

Last Name

Other Name: (AKA or Alias)

Last Name

Sex

☐

Male

☐

Female

☐

Nonbinary

Date of Birth

Height

Weight

Eye Color

Hair Color

Place of Birth (State or Country)

Social Security Number

Home

Address Street Address or P.O. Box

First Name

Middle Initial Suffix

First Name

Suffix

Driver's License Number

Billing
Number

(Agency Billing Number)

Misc.
Number

(Other Identification Number)

City

State ZIP Code

I have received and read the included Privacy Notice, Privacy Act Statement, and Applicant's Privacy Rights.

Applicant Signature

Date

Your Number:

OCA Number (Agency Identifying Number)

Level of Service:

☒

DOJ

☒

FBI

If re-submission, list original ATI number:

(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Homecare LLC

Employer Name

1370 Valley Vista Dr

Street Address or P.O. Box

Diamond Bar

City

CA

State

91765

ZIP Code

9092429273

Telephone Number (optional)

15798

Mail Code (five digit code assigned by DOJ)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

ISID

ATI Number

Amount Collected/Billed