ACCLAIM HOME CARE

"Where Our Family Cares for Your Family"

ACCLAIM HOME CARE SERVICES, INC.
7405 NW 57th Street
Tamarac, FL 33319

Important Documents Needed For Application
It's Very Important That All Documents Are Provided

RN/LPN/HHA/CNA/MSW License

Professional Liability Ins. (Required)

CPR Card

Physical (No Less Than 6mths)

Car Insurance (If Applicable)

HIV/AIDS (Annual)

OSHA (Annual)

Domestic Violence (Annual)

Medical Errors (Annual)

Alzheimer's

Driver's License

Social Security Card

Level 2 Background Check

Proof of Work Eligibility
(Work Permit/Resident Card/US Passport/Birth Certificate/Voters Registration)

ACCLAIM HOME CARE SERVICES, INC.

EMPLOYMENT APPLICATION

First:	M/I	Last:	SS#:	DOB:
Address:				
City:	State:	Zip:	Telephone:	

DESIRED POSITION

Position	Date You Can Start	Desired Salary
Are You Currently Employed:	If Employed, May We Inquire of Your Current Employer·	
Have You Applied to This Company Before:	If so, where & when:	

EDUCATION

High School	Name & Location of School:	
	Years Attended/Completed: (Diploma/Degree)	Date Graduated/Grade:
University/College Undergraduate	Name & Location of School:	
	Years Attended/Completed: (Diploma/Degree)	Date Graduated/Grade:
University/College	Name & Location of School:	
	Years Attended/Completed: (Diploma/Degree)	Date Graduated/Grade:
Trade, Business or Correspondence School	Name & Location of School:	
	Years Attended/Completed: (Diploma/Degree)	Date Graduated/Grade:

EMPLOYMENT HISTORY

Employer:		Job Title!
Address:		Duties:
Phone:		Salary.
Date From:	Date To:	Reason for Leaving:
Employer:		Job Title:
Address:		Duties:
Phone:		Salary:
Date From:	Date To:	Reason for Leaving:
Employer:		Job Title:
Address:		Duties:
Phone:		Salary:
Date From:	Date To:	Reason for Leaving:

REFERENCES

Name:	Occupation:
Address.	Relationship:
Phone Number:	Years Known:
Name:	Occupation:
Address:	Relationship:
Phone Number:	Years Known:
Name:	Occupation:
Address:	Relationship:
Phone Number:	Years Known:

PHYSICAL RECORD

Do you have any disabilities that prevent you from performing the work for which you are applying? If so, describe:

Have you ever been injured: Provide Details:

In case of emergency notify:

Name:

Address : Phone:

ADDITIONAL AREAS OF EXPERTISE

Areas of specialized study; research or additional experience:
List the foreign languages you speak fluently: Read: Write:
U.S. Military Service: Present membership in National Guard or Reserves : Rank:
Have you ever been in the U.S. Armed Force:
What is your present selective services classification:
Are you presently a member of Reserves or National Guard?
If so when is your enlistment up?

Applicant's Signature **Date**

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Employee Information/Availability Form

Last Name:	First Name:
Email Address:	Phone #:
Cellular #:	Discipline: ☐ RN ☐ LPN ☐ HHA/CNA
Emergency Contact:	

I understand that if I am employed, any misrepresentation or material omission made by me on this application will be sufficient cause for cancellation of this application or immediate discharge from the employer's services, whenever it is discovered.

The employer does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by local, state or federal law.

This application is current for 60 days. At the conclusion of this time, if I have not heard from the employer and still wish to be considered for employment, it will be necessary to fill out a new application.

If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice, and the employer reserves the same right to terminate my employment at any time, with or without cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no representative of the employer, other than an authorized officer, has the authority to make any assurances to the contrary. I further understand that any such assurances must be in writing and signed by an authorized officer.

I agree to submit to a physical examination at my cost, and understand that provided the company otherwise wished to hire me, my employment by the company depends upon the results of such examinations being acceptable to the company.

I also understand that if I am hired, I will be required to provide proof of identity and legal working authorization.

I represent and warrant that I have read and fully understand the foregoing and seek employment under these conditions.

Signature of Applicant _____ Date _____

ACCLAIM HOME CARE

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X The boxes below for the hours that you are ***AVAILABLE*** to work.							
	MON	TUES	WED	THUR	FRI	SAT	SUN
6-7AM							
7-8AM							
8-9AM							
9-10AM							
10-11AM							
11-12PM							
12-1PM							
1-2PM							
2-3PM							
3-4PM							
4-5PM							
5-6PM							
6-7PM							
7-8PM							
8-9PM							
9-10PM							
COMMENTS:							

Signature of Applicant _____ Date_____

Acclaim Home Care Services, Inc.
7405 NW 57th Street
Tamarac, FL 33319

TEL: 954-780-3717
FAX: 866-373-3081 and/or 954-858-8031

TO: _____ RE: **EMPLOYMENT VERIFICATION**

_____

_____

The following individual has applied for employment with ACCLAIM HOME CARE SERVICES, INC. Your verification of employment will be kept confidential.

APPLICANT AUTHORIZATION

I hereby authorize release of any and all information regarding my employment for reference verification. I further release and hold harmless all persons involved from any liability from any claim resulting from furnishing said information.

_____ _____

Print Applicant Name Date

_____

Signature

Applicant- Print Name, Date & Sign above. Complete the section below & return to HR Dept.

Social Security #:	Position Held:
Employment Dates: From: To:	Ending salary:
Reason For Leaving:	

Employment Verification:

1. Above information regarding employment record is correct: YES____ NO____
2. Employee/Applicant Evaluation:

	Outstanding	Good	Fair	Poor
Job Performance				
Job Knowledge				
Cooperation				
Attendance				

3. Eligible for Rehire? YES____ NO____
4. Comments: _____

_____ _____

SIGNATURE/TITLE **DATE**

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_____ _____
Print Applicant Name Date

_____
Signature

Applicant- Print Name, Date & Sign above. Complete the section below & return to HR Dept.

Social Security #:	Position Held:
Employment Dates: From: To:	Ending salary:
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Employment Verification:

5. Above information regarding employment record is correct: YES____ NO____
6. Employee/Applicant Evaluation:

	Outstanding	Good	Fair	Poor
Job Performance				
Job Knowledge				
Cooperation				
Attendance				

7. Eligible for Rehire? YES____ NO____
8. Comments: _____

_____ _____
SIGNATURE/TITLE **DATE**

TELEPHONE REFERENCE CHECK

Applicant's Name: _____
(Last) (First) (MI)

Position Applied For: _____

Person Contacted: _____ **Position & Dept**: _____

Date Called: _____ **2nd Try:** _____ **3rd Try:** _____

Employment Dates: From _____ To _____

Position Held: _____

Reason(s) for Leaving: _____

_____

_____

Eligible for Rehire: Yes( ) No( ) If No, State Reason(s): _____

_____

_____

Works Well with Others: Yes( ) No( ) If No, Explain: _____

_____

_____

Strong Points: _____

Weak Points: _____

Attendance: GOOD( ) AVERAGE( ) POOR( ) Explain: _____

_____

Overall Evaluation of Applicant: _____

_____

_____

Employment: Approved( ) Position Hired For: _____

Denied( ) Reason: _____

Comments: _____

_____

_____

_____

Reference check completed by: _____ **Date:** _____

ACCLAIM HOME CARE SERVICES, INC.

AUTHORIZATION TO RELEASE INFORMATION

I voluntarily give ACCLAIM HOME CARE SERVICES, INC. the right to make a thorough investigation of my past employment and activities, and agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I consent to take the pre-assignment physical examination and such future physical examinations as may be required by ACCLAIM HOME CARE SERVICES, INC. at such times and places they designate.

I understand that I will be required to follow the policies and rules of ACCLAIM HOME CARE SERVICES, INC. and that infractions of said rules may lead to termination of my contract. I also understand that my contract as an Independent Contractor may be terminated for any misstatement or omission in this application form.

_____ _____

Applicant's Signature Date

Acclaim Home Care Services, Inc.
7405 NW 57th Street
Tamarac, FL 33319

INDEPENDENT CONTRACTOR'S EMERGENCY INFORMATION SHEET

Employee Name: _____

Home Telephone Number: ( ) _____

Cellular Telephone Number: ( ) _____

Address: _____
Number Street

_____
City State Zip Code

Person(s) to Contact in Case of Emergency:

1. **Name: _____**

   Relationship: _____

   Telephone Number: ( ) _____

   Address: _____

   _____

2. **Name: _____**

   Relationship: _____

   Telephone Number: ( ) _____

   Address: _____

   _____

Other Important Contact Telephone Numbers: _____

_____

_____

ACCLAIM HOME CARE SERVICES, INC.

DIRECT EMPLOYEE AGREEMENT

This Agreement is entered into as of the _____day of _____,20_____, between

Acclaim Home Care Services, Inc. (hereinafter referred to as "the Company" and _____) hereinafter referred to as "the Employee".

1. **Duties and Responsibilities.** To perform job duties as specified in the Employee's Job Description (refer to Job Description). To obey and comply with all lawful and reasonable instructions given by supervisors including duties not specifically mentioned but which may be reasonably expected within the scope of work, to devote all time, attention, knowledge and skill during working hours exclusively to the business and interests of the Company and to work exclusively for the Company during the duration of this employee contract, not to enter into any contracts or other commitments on behalf of the Company without the written consent of the Company, to observe the Policies and Procedures set by the Company from time to time in the conduct of its business, for the purpose of this employee contract the parties undertake to act in good faith and guarantee that they shall neither do or not do anything which may prejudice or detract from the assets interests or rights of either of them or others.
2. **Competency and Probation.** The Employee guarantees that he/she is competent to carry out the services for which he/she has been employed under this employee contract and that he/she is properly qualified to occupy the post envisaged herein. Any material misrepresentation shall lead to summary termination of this contract; the Employee will be required to serve a probationary period of three months during which the Company will provide ongoing training and during which the Employee's performance and progress will be monitored
3. **Orientation, Rules, Regulations and Procedures.** Upon engagement the Employee will be required to participate in an orientation program. It is a duty of the Employee to read and understand the Company's Policies and Procedures, as well as the Grievance and Disciplinary Codes and Processes. A copy of this will be made available to the Employee. Compliance with such procedures is a term and condition of employment with the Company.
4. **Remuneration.** The Company shall pay the Employee an agreed salary every _2_ weeks. You will be remunerated on a biweekly rate of $_____or per visit rate of $_____as agreed, for the hours/visits worked as indicated. Taxes shall be deducted from the salary. The rate of remuneration will be reviewed on an annual basis. Your hourly rate is _____. You are paid on a per visit basis or salaried basis based on your position. The company requires that all work assigned be completed by the close of each business day.
5. **Withholding of Services.** It is the company's policy that should the Employee withhold services for whatever reason, a principle of "no work, no pay" shall apply. This policy applies if healthcare documentation is not provided as stated during Company orientation.
6. **Deductions.** The Company shall be entitled to deduct, from the Employees remuneration any amount that the Company is legally obliged to deduct, e.g. income tax, unemployment insurance, etc.; any amount in respect of which the Employee's written authority has been given; any amount for loss or damage to the Company that the Employee has caused.
7. **Medical Suitability and Testing.** The Employee hereby declares that there is no medical condition, either physical or psychological, of which he/she is aware that would impede his/her performance on the job, or hold an actual potential risk to the health and safety of the Employee himself, herself, a fellow employee or patients.

The company may, at its discretion, require the employee to undergo medical examinations from time to time should this appear necessary or justified. The Employee expressly agrees to submit himself/herself to alcohol and drug tests at the Company's discretion.

8. **Confidentiality.** The Employee acknowledges that during the course of employment with the Company, the Employee will become familiar with its confidential information including commercial and technical secrets and/or the confidential information of patients of the Company. The Employee will not disclose to others or make use of directly or indirectly, any confidential information of the Company or confidential information of patients of the Company or of others who have disclosed it to the Company under conditions of confidentiality, unless for a purpose authorized by the Company. If there is any doubt about whether any disclosure or use is for an authorized purpose, the Employee is to obtain a ruling in writing from the Company and is to abide by it. The Employee shall take reasonable security precautions to keep confidential all information deemed confidential and shall not make unauthorized copies. He/she further agrees to notify the Company immediately upon discovery of any unauthorized use or disclosure of confidential material and shall assist the Company in regaining such material. For the purpose of this clause, confidential information will be deemed to extend to all confidential medical records and commercial information, including, but not limited to the contents of patient records, computer records, patients lists, billing and reimbursement schedules, employee records and the like. The Employee is required to deliver to the Company whenever required to do so, or in any event when leaving the employment of the Company, all books of accounts, records, correspondence, training material, notes, computer disks, and the like concerning or containing any reference to the business of the Company or the Company's patients.
9. **Surrender of Documents.** Any documents or records or creations but not limited to written instructions, photographs, computer records, notes or memoranda relating to the business of the Company, which are made by the Employee or which come into the Employee's possession while he/she is employed by the Company, remains the property of the Company and shall be surrendered to the Company on demand and, in any event, on the date of termination of the Employee's employment with the Company. The Employee will not retain any copies thereof or any extracts there from.
10. **Copyright.** The Employee hereby assigns to the Company the total right, title and interest in and to any copyright in any existing or future works or part thereof of whatsoever nature that the Employee, individually or jointly with any other person(s) has made or created or will make or will create during the course and scope of the Employee's employment hereunder. The Employee expressly undertakes that all such works or copies thereof shall be delivered to the Company and that possession of such works that the Employee may have from time to time will be deemed to be possession on behalf of the Company as its agent.
11. **Notice of Termination.** Termination employment shall, under normal circumstances, be subject to one or more of the following stipulations:
    - During the first six months of employment, one-week written notice by either party;
    - After six months of employment and within one year of employment, two weeks written notice by either party;
    - After one year or more of employment, two weeks written notice by either party;
    - The Company shall have the right to pay the Employee in lieu of notice;
    - Failure to comply with the disciplinary rules and regulations or the policies and procedures of the Company as mended from time to time;
    - Failure to sign any reasonable restraint that the Company feels necessary.
    - The Company will be entitled to terminate the employment of the Employee other than the termination referred to above on, but not limited to, the following conditions:
        - In terms of the disciplinary code;

- For justifiable and/or persistent breach of employment duties due to incapacity or poor performance;
- Abscondment;
- Is convicted of any criminal offence;
- Failure to disclose relevant material information pertinent to the job requirements, or does so incorrectly, intentionally, vaguely or falsely in regulation to his/her employment application;
- Guilty of any other conduct which will justify dismissal at common law.

12. General. This employee contract and any exhibit attached constitute the sole and entire agreement between the parties with regard to the subject matter hereof and the parties waive the right to rely on any alleged express provision not contained herein. No party may rely on any representation, which allegedly induced that party to enter into this agreement, unless the representation is recorded therein. No agreement varying, adding to, deleting from or canceling this agreement and no waiver of any right under this agreement shall be effective unless it is:
    - In writing;
    - Agreed to by both parties
    - Signed by both parties
    - No relaxation by a party of any of its rights in terms of this agreement at any time shall prejudice or be a waiver of its rights (unless it is a written waiver) and it shall be entitled to exercise its rights hereafter as if such relaxation had not taken place.
    - No party may cede any of its rights or delegate or assign any of its obligations in terms of this employee contract without the prior written consent of the other parties.
    - Unless inconsistent with the context, words signifying any one gender shall include the others, words signifying the singular shall include the plural and vice versa and words signifying natural persons shall include artificial persons and vice versa.

By signing below, the Employee certifies under the penalty or perjury that the name and address given is the Employee's legal name, address and signature.

13. No Duress. The Employee acknowledges that he/she has read this employee contract in its entirety, fully understands all clauses and is signing this contract under his/her free will.

_____ _____

Company's Name Employee's Name

By: _____ Address: _____

Authorized Representative/Position _____

_____

Signature: _____ Signature: _____

Date: _____ Date: _____

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Malpractice Insurance

Nurses aides, LPN's and RN's are required to carry malpractice insurance if employed by ACCLAIM HOME CARE SERVICES, INC. This is for your protection as a(n) per-diem/independent service provider as well.

Options: PLEASE CHECK ONE

_____1. Obtain a malpractice insurance contract on your own which will be verified.

_____2. We have listed 2 available choices of recommended malpractice insurance companies below.

		CNA	**LPN/RN**
☐	1. Nurses Service Organization (NSO) Contact #: 888-288-3534	$500,000/2.5M - $41/YR	$1M/3M - $288L/$145R
☐	2. CM & F Group, Inc. Contact #: 212-233-8911	$500,000/500,000 - $47/YR	$1M/1M - $99/YR

I, _____, understand and agree to obtain malpractice insurance as required as an employee of ACCLAIM HOME CARE SERVICES, INC.

Signature: _____

Date: _____

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PHYSICIAN STATEMENT
&
PHYSICAL EXAMINATION

Independent Contractor/Employee: _____ Date: _____
(Please Print)

Address: _____

Telephone: _____ Age: _____ Sex: _____

Position Applied For: _____

Last Date of Hospitalization: _____ Reason: _____

Drug Allergies: _____

Temperature: _____ Pulse: _____ Respiration: _____ Blood Pressure: _____

Height: _____ Weight: _____

Is this person capable of working in the position applied for? Remarks _____

Is this person a positive TST reactor? ☐ Yes ☐ No

If yes, date of chest x-ray _____ Results: ☐ Positive ☐ Negative

ANSWERS TO THE FOLLOWING QUESTIONS ARE REQUIRED BY THE STATE.

Is this person free of communicable diseases? ☐ Yes ☐ No

Mantoux Method Tuberculin Skin Test (TST) ☐ Negative ☐ Positive

This individual is in good health sufficient to provide services to individuals with compromised health & does not constitute a risk of communicating diseases to any person under his/her care.

_____ _____
Physician's Signature License No.

_____ _____
Please Print Physician Name Date

Acclaim Home Care Services, Inc.
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TUBERCULOSIS QUESTIONNAIRE

Name_____ Date of Birth_____

Please indicate if you are experiencing any of the following symptoms or if any of the following apply to you:

	YES	NO
1. Unplanned loss of weight.	___	___
2. Sweating in bed at night.	___	___
3. Fever slightly above your normal and lasting several days or weeks.	___	___
4. Frequent coughing in the absence of a cold or flu.	___	___
5. Coughing blood-streaked sputum.	___	___
6. Unusual tiredness lasting several weeks.	___	___
7. Pain in chest when breathing.	___	___
8. Part of stomach has been removed.	___	___
9. History of cancer.	___	___
10. Taking any prescription medicines.	___	___

If yes, name them_____
_____
_____
_____

I understand that if at any time I begin to experience any of the above, I am to report immediately to the Administrator or Supervisor.

_____ _____
Signature Date