Protection of Health Information

There are specific guidelines to ensure patient's Protected Health Information is kept private. I understand that my employment with this Agency Involves handling Protected Health Information. I will ensure patient's records are protected by enforcing the following measures:

- Patients Protected Health Information will be transported in a protective travel chart when travelling.
- When transmitting and receiving fax involving Protected Health Information, I will ensure that it is conducted in a private location.
- Patients Protected Health Information will be returned to the Agency upon acknowledgement of patient being discharged.

I pledge to make every effort to keep patient's Protected Health Information protected at all times.

Applicant Name: _____

Date: _____

HIPAA Confidentiality Agreement

EMPLOYEE CONFIDENTIALITY AGREEMENT of PATIENT'S HEALTH INFORMATION AND PERSONAL INFORMATION in accordance with HIPAA REGULATIONS.

For good consideration and as an inducement for

Massachusetts Care Services, Inc (employer) to hire _____ (employee), the undersigned Employee hereby agrees not to directly or indirectly use, manipulate, or copy any patient's health information (PHI) to include personal health information or personal contact information such as (address, phone number, email address, etc.) with the business of the Agency and its successors and assigns during the period of employment. Misuse of PHI or personal contact information will result in termination and report with action to the HIPAA federal agencies. Fines related to civil and criminal offenses for gross misconduct with the above information are the direct responsibility of said employee.

The Employee acknowledges that this Agency shall or may in reliance of this agreement provide Employee access to trade secrets, customers or other confidential data of good will. Employee agrees to retain said information confidential and not to use said information on his or her own behalf or disclose information to any third party, or for their own personal/ monetary gain.

The Employee agrees to not copy and to return all such Agency supplied information immediately upon termination of employment. Further employee agrees not to solicit any of the customers/employee's information of this Agency for any purpose for a period of two years after termination.

This agreement shall be binding upon and inure to the benefit of the parties, their successors, assigns, and personal representatives.

Signed this _____ day of _____ 20___

Manager of HR _____

Employee Policies and Procedures

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, understand, and confirm to all applicable Agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Massachusetts Care Services, Inc Policy and Procedure on Abuse, Neglect and Exploitation and agree to comply with and be bound by the Policy. I understand that information contained in any MCS' manual does not constitute a contractual relationship between MCS and its employees, not is it an expression of my term of employment.

I affirm that I have auto insurance coverage as required by the state of Massachusetts. MCS and I agree to keep it fully enforce on any vehicle I use for the conduction of this Agency business during the term of employment. MCS has the right to request proof of insurance at any time during the term of employment and that I am required to follow all MCS' requirements, state and local laws.

I understand that only MCS has the authority to admit clients and will supervise with appropriate personnel, all services provided.

As a caregiver, I will carry out the plan of treatment, submit timesheets, clinical and progress notes in an appropriate time on a weekly basis. I will participate in the development and reviewing of the Plan of care, periodic client evaluation and care conferences, discharge planning, and schedule coordination. I will provide services within the geographic are covered by MCS. I will attend required monthly staff meeting and in-service training. Home Health Aides/PCA/Homemaker are required to have 12 hours of in-service training annually.

I understand that I must remit documentation of services performed prior to payment for those services, and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for service provided. I understand that all information, both written and verbal, regarding client and employee health conditions is strictly confidential and protected under federal and state law. The presence of communicable or venereal disease, testing, results or known infection by HIV, Hepatitis, Tuberculosis, information concerning child abuse, mental health, drug or alcohol abuse is protected under specific laws. All information in connection with the examination, care or provision of services to any client will not be disclosed without the individual's written consent except as may be necessary to provide services as required by law. Information may be used in statistical or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of client/employee confidentiality is subject to civil and criminal penalties.

If mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize MCS to deduct any amount from my paycheck to correct my accrued/earned sick/vacation leave balance. I understand that MCS does not routinely perform drug testing on its employees but may do so at its discretion. I understand that MCS is an "AT Will": organization and may hire or fire at will.

Applicant Signature: _____ Date: _____

Field Employee Standards and Procedures

This Agency requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to health care environment., or as directed by a patient/client/family. This includes personal hygiene, jewelry, hair, and makeup.
2. Please do not smoke in the presence of a patient/client.
3. Always wear your ID badge
4. You are expected to arrive on time to all assignment that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more, or to be totally absent from the assignments, you must notify MCS or the Administrator (Peter Jean at 508 232 5652). *PLEASE DO NOT CALL YOUR PATIENT DIRECTLY*. You may call the Administrator Peter Jean at 508 897 0800)24 hours a day if you need to cancel or reschedule your assignment. *A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION*.
5. If you have any problem, incident or accident on the job, do not discuss it with the patient/client, but immediately call the Administrator Peter Jean at 508 232 5652.
6. If the patient/client request for you to stay longer than your assigned time or request for you to leave earlier, you must call the Administrator Peter first for approval.
7. Paraprofessional personnel (i.e., Aides) hereby acknowledge that they *WILL NOT, UNDER ANY CIRCUMSTANCE, DISPENSE OR ADMINITER ANY MEDICATION.*
8. UNDER NO CIRCUMSTANCES are you to ask for, or accept any money from your patient/client or take-home property that belongs to the patient/client.
9. There shall not be any involvement with the patient/clint's financial affairs (i.e., check writing)
10. You are expected to honor the confidentiality of any patient/client information which is obtained in the regular course of your employment.
11. No personal telephone calls should be made or received by you while on assignment.
12. Please do not discuss your pay or any other personal affairs with patient/client/family.
13. As an employee of Massachusetts Care Services, Inc, you are not authorized to accept any direct employment that may be offered to you by your patient/client/family. If you are requested to do so, please have the patient/client contact the Administrator- Peter Jean.
14. It is imperative that all signed notes and documentation including Daily log to be filled out properly and returned to MCS as per schedule. If the patient/client is unable to sign your note, a family member or responsible party may sign.
15. During the course of employment, Massachusetts Care Services, Inc's proprietary materials (i.e., forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from MCS.

Applicant Signature: _____

Date: _____

Job Acceptance Statement.

I, _____ have read, understand, and agree to the terms specified in the job description for the position of _____ for which I have been hired.

A copy of the job description for this position has been given to me and it may be reviewed at any time and if revised, I will provide the revised copy.

I understand that I will be paid $ _____ for the time worked an employee of Massachusetts Care Services, Inc.

NOTE: This agency provides worker's compensation insurance for its employees.

Applicant Signature: _____

Date: _____

Massachusetts Care Services, Inc.
37 Belmont Street, Ste D. Brockton MA 02301/Tel:508 897-0800/Fax: 508 484-7300

Employee Counseling Report

Applicant Name:

_____

Date: _____

Job Classification

Reason for Conference/Report:

Commendation
Work Performance
Infraction of Policy
Other (Specify): _____

Type of Communication:
Telephone
Office conference
Field Conference
Other (specify): _____

Events leading to conference session:_____

_____

_____

_____

Handling of event/session:_____

_____

_____

_____

Recommendation to Employee:_____

_____

_____

_____

_____Employee

Comment:_____

_____

_____

_____

Applicant Signature: _____ Date: _____

Massachusetts Care Services, Inc.
37 Belmont Street, Ste D. Brockton MA 02301/Tel:508 897-0800/Fax: 508 484-7300

Counselor Signature: _____ Date: _____

Confidentiality and Non- Competition Agreement

Massachusetts Care Services, Inc requires that the Employee avoid disclosure of confidential information to anyone outside of our Agency and refrain from engaging in unfair competition.

The employee agrees to refrain from prohibited competition with MCS and to maintain the confidentiality of information regarding employees, clients, and MCS business.

The Employee will have access to information not generally made available to the public, such as identity of clients, pricing, computer-related, tec. MCS prohibits the utilization of this information for any purposes other than for MCS' own benefit and prohibits disclosure or unauthorized use during the course of employment or at any time thereafter of any confidential information pertaining to MCS administration and/or projects, or outside investigation of the Agency. The employee is prohibited from disclosing any defaming information regarding Agency personnel and/or personnel incidents related to any violations of the personnel policies.

During the course of employment and for a twelve month period thereafter the Employee is prohibited from engaging in any of the following: induce any employee of MCS to resign, encourage any client or entity to discontinue any relationship with MCS, solicit any client of the Agency (current and within the past twelve month period), enter into competitive employment or seek to provide competitive services while employed within 25 miles of any office of the Agency, or solicit referrals or opportunities from any referral source.

Upon termination of employment or at the request of MCS, the employee is required to return all of MCS' property including keys, ID badge, client records, forms, manuals, beeper, etc., to MCS and will not retain copies.

This agreement is in effect during the employee's employment period and for 12 months thereafter. It does not modify the right of the employee to resign at any time or of the Agency to terminate employment without prior cause, notice or liability and does not modify any other Agency policy.

Violation of this agreement will result in termination and /or non-rehire status and any additional remedy available to MCS including legal action to remedy all damages including loss of profits, cost of replacing and training employees improperly solicited for competitive employment, etc. suffered by the Agency.

Applicant Signature: _____ Date: _____

TB Targeted Medical Questionnaire Form

Applicant Name: _____

YES NO

Have you ever had a positive TB skin test or history of TB infection? _____

_____

Have you ever had BCG vaccine? _____

_____

Do you have prolonged or recurrent fever? _____

_____

Have you recently lost weight? _____

_____

Do you have chronic cough? _____

_____

Do you cough up blood? _____

_____

Do you have sweating at nights? _____

_____

Do you have any of the following risk factors which may substantially increase the risk of tuberculosis?

_____ a. Silicosis (Lung Disease)

_____ b. Gastrectomy

_____ c. Intestinal Bypass

_____ d. Weight 10% or more below ideal body weight

_____ e. Chronic Renal Disease

_____ f. Diabetes Mellitus

_____ g. Prolonged high dose corticosteroid therapy or other Immunosuppressive therapy

_____ h. Hematologic Disorder i.e., leukemia or lymphoma

_____ i. Exposure to HIV or AIDS

_____ j. Other malignancies

Applicant Signature: _____ Date: _____

Health Statement

Applicant Name: _____ Date: _____

I, _____ hereby attest that the state of my health is such that it will enable me to perform the duties of a health professional. I further specifically attest that I am free of any and all potentially contagious disease including, but not limited to those listed below.

AIDS	Anthrax	Chicken ox	Cholera
Diphtheria	Encephalitis	Hepatitis, Types A, B and C	Influenza
Leprosy (Hansen's Disease	Leptospirosis	Malaria	Measles (Rubeola)
Meningitis	Mononucleosis	Mum $	Whooping Cough
Plague	Poliomyelitis	Psittacosis Ornithosis	Rabies
Rocky Mountain Spotted Fever	Rubella (German Measles	Shigellosis	Smallpox
Tetanus	Tularemia	Tuberculosis	Typhoid Fever

Applicant Signature: _____ Date: _____

Massachusetts Care Services, Inc.
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ORIENTATION PROGRAM			
	CHECK		CHECK
Agency Mission, Vision and Plan and Organizational Chart		Advance Directives	
Types of Care Provided by the Agency including Information Provided to Clients Regarding Charges		Policies and Procedures	
Personnel Policies, Job Descriptions and Professional Boundaries of All Disciplines		Training Specific to Job Descriptions	
Cultural diversity		Client Rights and Grievance Policy	
Ethics, Conflict of Interest and Confidentiality of patient Information		Supervision and Evaluation	
Home Safety (including Bathroom, Electrical, Environment, Fire and Hazards)		Safety Issues in the Home (Including Security and Guns in the Home)	
Emergency Preparedness Plan/Actions to Take in the Event of a Disaster		Actions to Take in Unsafe Situations	
OSHA Requirements, Safety and Infection Control in the Home/Standard Precautions		Patient Care Responsibilities Including Charges for Service/Care	
Incidences and Occurrences reporting		Exposure Control Plan	
Recognizing and Reporting Abuse, Neglect, Mistreatment and Exploitation		Medicare/Fraud/Abuse/Corporate Compliance, False Claims, False Statements, Whistle Blowing	
Community Resources		Quality Assurance	
Documentation - Record Keeping including OASIS		ID Badge Issued	
Medical Device/Hazards reporting			

PRINT NAME	TITLE
APPLICANT SIGNATURE	DATE
PRINT NAME	TITLE
EMPLOYER SIGNATURE	DATE

Interview Review

Applicant Name: _____ Date: _____

Days Available: Mon Tues Wed Th Fri Sat Sun

Review;			
Personality;	friendly	average	quiet
Verbal skills:	excellent	average	poor
Communicates:	clear	somewhat clear	not very clear
Flexibility:	very flexible	somewhat	not flexible
Ski!! level:	higher skilled	moderately skilled	lower skilled
Appearance:	professional	semi-professional	not professional

Good Candidate for employment: ☐ YES ☐ NO

Overall Interview:

Interviewer: _____ Date:

_____

Massachusetts Care Services, Inc.
37 Belmont Street, Ste D. Brockton MA 02301/Tel:508 897-0800/Fax: 508 484-7300

Hepatitis Vaccine Requirement

I, _____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that MCS will arrange for me to receive the Hepatitis vaccine at no cost to myself. It I my decision to:

☐ request that I receive the Hepatitis vaccine

☐ refuse the Hepatitis vaccine and HOLD HARMELSS THE AGENCY. I understand that by declining the vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or potentially infectious materials, and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

☐ provide written proof of immunity (attach)

☐ provide written proof of previous vaccination (attach)

☐ provide written proof of medical contraindication (attach)

Applicant Signature: _____

Date: _____

Employee Payment Schedule

Classification	MONDAY-FRIDAY	OASIS	EVALS	VISIT & DC	MRC EVALS	RECERT	SUP VISIT
HR Coordinator	$12.50 / HOUR						
C.N.A. / HHA	$13.50/ HOUR						
	$13.00/ HOUR						
Chore Worker	$14.00/HOUR						
HMK/PCA	$12.00/HOUR						
Companion	$11.00/HOUR						
01			$50.00	$40.00	$45.00	$45.00	
		$60.00	$55.00	$50.00			
SN		$45.00		$32.00	$32.00	$40.00	
Psych RN		$52.00		$35.00		$48.00	
				$25.00	$25,00		
EDTA/COTA				$25.00			
MSW				$35.00			
SLP			$50.00	$45.00			

Depending on the difficulty, distance or other unusual circumstance of the case, the reimbursement rate may be adjusted accordingly.

All timesheets must be turned into the office on everyday Payday. If it happens that Payday falls on a holiday, please turned documents into the office on the next business day. If you submit your timesheets late, there might be consequences such as late payment.

HR Signature: _____ Date: _____

Applicant Signature: _____ Date: _____

Exit Interview

Massachusetts Care Services, Inc.
37 Belmont Street, Ste D. Brockton MA 02301/Tel:508 897-0800/Fax: 508 484-7300

Your comments are important to us. Please complete the questions on this form. Your answers will be used to develop recommendations for improvement, please be candid with us.

Name: _____ Title: _____
Date of Hire: _____ Date of Resignation: _____

1. Most important reason for leaving?
   _____
   _____
   _____
2. Was the information given to you about your job concerning hours, salary, and job duties an accurate reflection of what you found on the job?
   _____
   _____
   _____
3. Were you adequately prepared to perform your job? If not, what could have been done to help you perform more effectively?_____
   _____
   _____
4. What did you like best about working for MCS?_____
   _____
   _____
   _____
5. What did you like least about working for MCS?_____
   _____
   _____
   _____
   _____
6. Did you receive sufficient information about your performance?_____
   _____
   _____
   _____
   _____

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