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## PRE-HIRE FORMS

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## EMPLOYMENT APPLICATION

**Availability: check all that you could work**

Mon\_\_\_\_ Tues\_\_\_\_ Weds\_\_\_\_ Thurs\_\_\_\_ Fri\_\_\_\_ Sat\_\_\_\_ Sun\_\_\_\_

Date of Application: \_\_\_\_\_ Date Available for Employment: \_\_\_\_\_

Position Applying for: \_\_\_\_\_

Type of Employment Desired:      Per Diem      Number of Hours: \_\_\_\_\_  
Part Time      Number of Hours: \_\_\_\_\_  
Full Time      Number of Hours: \_\_\_\_\_

LAST NAME

FIRST NAME

MIDDLE INITIAL

MAILING ADDRESS

CITY

STATE

ZIP CODE

HOME PHONE NUMBER

CELL PHONE NUMBER

WORK PHONE NUMBER

DOB

SSN

EMAIL ADDRESS

LANGUAGE SKILLS OTHER THAN ENGLISH (WRITTEN/SPOKEN)

Have you ever been employed here before?      Yes      No      If yes, when? \_\_\_\_\_

Are you legally eligible for employment in the US?      Yes      No

If not legal citizen: Do you have a green card?      Yes      No

Do you have a social security card?      Yes      No

Has your visa expired?      Yes      No

### REFERRAL INFORMATION

How did you hear about us? (Please check)

Newspaper Ad \_\_\_\_\_ Internet \_\_\_\_\_

Which newspaper?

Which site?

Current Employee \_\_\_\_\_

We'd like to thank them

Other \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION - Please Print Clearly

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone Number: (\_\_\_\_\_) \_\_\_\_\_

Work Phone Number: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone Number: ( )

Signal Health Group Inc. is an equal opportunity employer. All applicants and employees are considered for employment, advancement, and development based upon their skills, performance and potential. No current or prospective employee will be discriminated against because of race, creed, color, gender, age, national origin, handicap or military status.

**Employment History** - *Please begin with your most recent or current place of employment.*

Place of Employment:

Start Date:

Address:

End Date:

Position:

Phone Number:

Supervisor:

Salary:

Reason for Leaving:

Final Salary:

Place of Employment:

Start Date:

Address:

End Date:

Position:

Phone Number:

Supervisor:

Salary:

Reason for Leaving:

Final Salary:

Place of Employment:

Start Date:

Address:

End Date:

Position:

Phone Number:

Supervisor:

Salary:

Reason for Leaving:

Final Salary:

Education	Name & Location	Course of Study	Years Completed	Date Graduated
High School:				
College:				
Other:				
Other:				
Military Service				
Branch of Service:		Dates of Service:		
Highest Rank Achieved:		Currently in a Reserve Unit?	YES	NO
Special Schooling and/or Duties:				

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**Licenses and Certifications**

	License or Certification	ID Number	Expiration Date	State
1.	<hr/>			
2.	<hr/>			
3.	<hr/>			

**Criminal History- By my signature below, I acknowledge/consent to a criminal check on my name.**

Have you ever been convicted of violating any law? (Please omit minor traffic violations.)

Yes                  No                  If yes, please list conviction(s), date(s) and location(s). The presence of a criminal record is not an automatic rejection of your application. Certain types of convictions will eliminate you from servicing vulnerable elders in their homes. I attest that the above referenced information is true and accurate to the best of my knowledge. I further give the Agency permission to call any of my cited previous employers or reference candidate for information regarding my character, employment history or work ethics.

<hr/>	<hr/>
Employee Candidate Signature	Date

**Pre-Hire Home Health AIDE Read/Write/Report Competency**

Signal Health Group Inc.

☐ **SECTION A**

writing

**\*\* Ask the Applicant to fill in the following 4 lines.**

**Name:**

**Position Applying for:**

**Today's Date:**

**Agency Name:**

☐ **SECTION B**

reading

**\*\* Ask the Applicant to read aloud the following:**

Mary is my patient who I see every week on Monday and Thursday. Mary's plan of care includes assist with bathing, blood pressure, and reporting all skin changes to the nurse. One day you go to her home and find Mary eating an apple for lunch and when assisting her with bathing, you see a large open cut on her leg you had not seen before.

☐ **SECTION C**

verbally report clinical changes

**\*\* Ask the Applicant the following 2 questions & record the answers:**

**Is there anything you need to report about Mary:**

**Who will you report this to:**

*TO BE COMPLETE BY AGENCY PRE-HIRE STAFF:*

**SCORE (indicate 1 or 2 score for A, B & C)**

Section A Score: 1. Completed    2. Unable to complete: \_\_\_\_\_

Section B Score: 1. Able to read    2. Unable to read: \_\_\_\_\_

Section C Score:

1. ID item to report & to whom    2. Unable to determine what/to whom to report clinical changes: \_\_\_\_\_

\*\*\*\* Must have all "1"s for hire.

**Agency Hiring Staff Signature**\_\_\_\_\_ **Date**\_\_\_\_\_

**AGENCY EMERGENCY HIRE AFFIDAVIT**

I HAVE NOT BEEN CONVICTED OF ANY OF THE FOLLOWING PENAL CODE OFFENSES, WHICH MAY POTENTIALLY BAR EMPLOYMENT.

I ACKNOWLEDGE THAT IF I AM FOUND TO HAVE BEEN CONVICTED OF ANY OTHER OFFENSES, THEY MAY CAUSE MY EMPLOYMENT TO BE TERMINATED. I UNDERSTAND THAT ALL INFORMATION OBTAINED BY THIS AGENCY REGARDING ANY CRIMINAL HISTORY WILL REMAIN CONFIDENTIAL. I CERTIFY THAT THE INFORMATION ON THIS FORM CONTAINS NO WILLFUL MISREPRESENTATION AND THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
APPLICANT’S PRINTED NAME

IF ARRESTED / CONVICTED OF ANY OFFENSE LISTED, PLEASE PROVIDE EXPLANATION:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

# AGENCY EMERGENCY HIRE AFFIDAVIT

DUE TO THE LACK OF SUFFICIENT PERSONNEL TO ADEQUATELY AND SAFELY CARE FOR OUR PATIENTS NEEDS, WE ARE HIRING \_\_\_\_\_. HE/SHE HAS CONSENTED TO A CRIMINAL HISTORY CHECK TO BE PERFORMED AS PART OF OUR HIRING PROCESS. DURING THE SIXTY (60) DAY WAITING PERIOD ON THE CRIMINAL HISTORY CHECK, THIS DOCUMENT WILL SERVE AS AN ACKNOWLEDGEMENT THAT THE ABOVE-NAMED PERSON STATES THAT THEY HAVE NO CONVICTION OF AN OFFENSE WHICH WOULD BAR EMPLOYMENT.

## OFFENSES WHICH WOULD BAR EMPLOYMENT (POLICY P:5)

- (1) MURDER, VOLUNTARY MANSLAUGHTER OR MAYHEM;
- (2) ASSAULT OR BATTERY WITH INTENT TO KILL OR TO COMMIT SEXUAL ASSAULT OR MAYHEM;
- (3) SEXUAL ASSAULT, STATUTORY SEXUAL SEDUCTION, INCEST, LEWDNESS OR INDECENT EXPOSURE, OR ANY OTHER SEXUALLY RELATED CRIME THAT IS PUNISHED AS A FELONY;
- (4) PROSTITUTION, SOLICITATION, LEWDNESS OR INDECENT EXPOSURE, OR ANY OTHER SEXUALLY RELATED CRIME THAT IS PUNISHED AS A MISDEMEANOR, WITHIN THE IMMEDIATELY PRECEDING 7 YEARS;
- (5) A CRIME INVOLVING DOMESTIC VIOLENCE THAT IS PUNISHED AS A FELONY;
- (6) A CRIME INVOLVING DOMESTIC VIOLENCE THAT IS PUNISHED AS A MISDEMEANOR, WITHIN THE IMMEDIATELY PRECEDING 7 YEARS;
- (7) ABUSE OR NEGLECT OF A CHILD OR CONTRIBUTORY DELINQUENCY;
- (8) A VIOLATION OF ANY FEDERAL OR STATE LAW REGULATING THE POSSESSION, DISTRIBUTION OR USE OF ANY CONTROLLED SUBSTANCE OR ANY DANGEROUS DRUG AS DEFINED IN CHAPTER 454 OF NRS, WITHIN THE IMMEDIATELY PRECEDING 7 YEARS:
  - A. ANY DRUG WHICH HAS BEEN APPROVED BY THE FOOD AND DRUG ADMINISTRATION FOR GENERAL DISTRIBUTION AND BEARS THE LEGEND: "CAUTION: FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION";
  - B. PROCAINE HYDROCHLORIDE WITH PRESERVATIVES AND STABILIZERS (GEROVITAL H<sub>3</sub>) IN INJECTABLE DOSES AND AMYGDALIN (LAETRILE) WHICH HAVE BEEN LICENSED BY THE STATE BOARD OF HEALTH FOR MANUFACTURE IN THIS STATE BUT HAVE NOT BEEN APPROVED AS DRUGS BY THE FOOD AND DRUG ADMINISTRATION; OR
  - C. ANY DRUG WHICH, PURSUANT TO THE BOARD'S REGULATIONS, MAY BE SOLD ONLY BY PRESCRIPTION OR BECAUSE THE BOARD HAS FOUND THOSE DRUGS TO BE DANGEROUS TO PUBLIC HEALTH SAFETY.
- (9) ABUSE, NEGLECT, EXPLOITATION OR ISOLATION OF OLDER PERSONS OR VULNERABLE PERSONS, INCLUDING, WITHOUT LIMITATION, A VIOLATION OF ANY PROVISION OF NRS 200.5091 "CRIMES AGAINST A PERSON" TO 200.50995, "PENALTIES FOR CONSPIRACY", INCLUSIVE, OR A LAW OF ANY OTHER JURISDICTION THAT PROHIBITS THE SAME OR SIMILAR CONDUCT;
- (10) A VIOLATION OF ANY PROVISION OF LAW RELATING TO THE STATE PLAN FOR MEDICAID OR A LAW OF ANY OTHER JURISDICTION THAT PROHIBITS THE SAME OR SIMILAR CONDUCT, WITHIN THE IMMEDIATELY PRECEDING 7 YEARS;
- (11) A VIOLATION OF ANY PROVISION OF NRS 422.450 "FALSE CLAIMS" TO 422.590, "LIMITATION AND ACCRUAL OF ACTIONS", INCLUSIVE;
- (12) A CRIMINAL OFFENSE UNDER THE LAWS GOVERNING MEDICAID OR MEDICARE, WITHIN THE IMMEDIATELY PRECEDING 7 YEARS;
- (13) ANY OFFENSE INVOLVING FRAUD, THEFT, EMBEZZLEMENT, BURGLARY, ROBBERY, FRAUDULENT CONVERSION OR MISAPPROPRIATION OF PROPERTY, WITHIN THE IMMEDIATELY PRECEDING 7 YEARS;
- (14) ANY OTHER FELONY INVOLVING THE USE OR THREATENED USE OF FORCE OR VIOLENCE AGAINST THE VICTIM OR THE USE OF A FIREARM OR OTHER DEADLY WEAPON; OR
- (15) AN ATTEMPT OR CONSPIRACY TO COMMIT ANY OF THE OFFENSES LISTED IN THIS PARAGRAPH, WITHIN THE IMMEDIATELY PRECEDING 7 YEARS;
  - (A) THE LICENSEE HAS, IN VIOLATION OF NRS 449.125, CONTINUED TO EMPLOY A PERSON WHO HAS BEEN CONVICTED OF A CRIME LISTED IN PARAGRAPH (A); OR
  - (B) THE APPLICANT OR LICENSEE HAS HAD A SUBSTANTIATED REPORT OF CHILD ABUSE OR NEGLECT MADE AGAINST HIM OR HER AND IF THE FACILITY, HOSPITAL, AGENCY, PROGRAM OR HOME PROVIDES RESIDENTIAL SERVICES TO CHILDREN.

(16) IN ADDITION TO THE GROUNDS LISTED IN NRS 449.160, "GROUNDS FOR DENIAL, SUSPENSION OR REVOCATION OF LICENSE", THE DIVISION MAY SUSPEND OR REVOKE THE LICENSE OF A LICENSE TO OPERATE AN AGENCY TO PROVIDE PERSONAL CARE SERVICES IN THE HOME OR AN AGENCY TO PROVIDE NURSING IN THE HOME IF THE LICENSEE HAS, IN VIOLATION OF NRS 449.125, "TERMINATION OF EMPLOYMENT", CONTINUED TO EMPLOY A PERSON WHO HAS BEEN CONVICTED OF A CRIME LISTED ABOVE.

IF WE DO NOT RECEIVE A RESPONSE FROM THE INDIANA DEPARTMENT OF PUBLIC SAFETY WITHIN SIXTY (60) DAYS, IT IS LIKELY THAT NO CONVICTIONS WERE FOUND. YOU WOULD NO LONGER BE ON AN 'EMERGENCY HIRE' STATUS.

IF, HOWEVER, A CONVICTION IS FOUND, INDIANA DEPARTMENT OF PUBLIC SAFETY WILL NOTIFY US AS WELL AND SEND THE SAME INFORMATION TO YOU. YOU WILL BE GIVEN INSTRUCTIONS AS TO WHAT OPTIONS YOU HAVE AVAILABLE TO YOU. THEY WILL SEND US A NOTICE OF DETERMINATION AS TO WHETHER YOU ARE EMPLOYABLE. WE WILL ABIDE BY THIS DETERMINATION. ALL INFORMATION CONCERNING YOUR CRIMINAL HISTORY WILL REMAIN CONFIDENTIAL.

I, \_\_\_\_\_ **CONSENT TO A CRIMINAL HISTORY CHECK AND FURTHER STATE THAT I HAVE NO CONVICTION FOR ANY OF THE OFFENSES LISTED ABOVE. I UNDERSTAND AND AGREE TO THE TERMS OF THIS AGREEMENT.**

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF WITNESS

\_\_\_\_\_  
DATE

**QUESTIONS FOR BACKGROUND CHECK:**

1. PLACE OF BIRTH:

2. PRIOR STATES LIVED AND YEARS LIVED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**REFERENCE FORM #1**

First and Last Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone & Fax Number: \_\_\_\_\_

The individual listed below has applied for a position with Signal Health Group Inc.

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

The position being applied for is: \_\_\_\_\_

**APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION**

I hereby give permission for my previous employer to release this referral information about my position with their company and comments regarding my work ethic and character while in their employ.

Applicant's Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

*THIS SECTION TO BE COMPLETED BY PERSON COMPLETING THIS REFERENCE*

Employment dates: From \_\_\_\_\_ to \_\_\_\_\_ Position: \_\_\_\_\_

Reason for separation: \_\_\_\_\_

Would you rehire? \_\_\_\_\_ If no, why not? \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

Signature/Title of Reference

Date

**REFERENCE FORM #2**

First and Last Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone & Fax Number: \_\_\_\_\_

The individual listed below has applied for a position with Signal Health Group Inc.

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

The position being applied for is: \_\_\_\_\_

**APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION**

I hereby give permission for my previous employer to release this referral information about my position with their company and comments regarding my work ethic and character while in their employ.

Applicant's Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

*THIS SECTION TO BE COMPLETED BY PERSON COMPLETING THIS REFERENCE*

Employment dates: From \_\_\_\_\_ to \_\_\_\_\_ Position: \_\_\_\_\_

Reason for separation: \_\_\_\_\_

Would you rehire? \_\_\_\_\_ If no, why not? \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

Signature/Title of Reference

Date

# CORPORATE COMPLIANCE POLICY ACKNOWLEDGEMENT FORM

\*Must be signed by all employees

## CORPORATE COMPLIANCE POLICY ACKNOWLEDGEMENT

Our Home Care Agency is committed to providing the highest ethical health care and upholding conduct standards and corporate legal compliance.

Our policies and Corporate Compliance Plan clearly support a 'zero' tolerance to any form of fraud or misconduct. This applies to all employees, direct and contracted, regardless of position or title.

I, as an employee of the Agency, acknowledge that I have apprised of and agree to comply with the Agency's Corporate Compliance Policy.

I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.

**SIGNAL HEALTH GROUP, INC.**

EMPLOYEE'S PRINTED NAME: \_\_\_\_\_

EMPLOYEE'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

# AUTOMOBILE USE AGREEMENT

This agreement is made this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ between the Agency and \_\_\_\_\_ referred to hereinafter as "Applicant". The duties to be performed by Applicant will require the use of an automobile. The following are the conditions governing automobile use by Applicant:

## Use of Insurance Coverage of an Applicant's Automobile:

Applicant shall furnish Applicant's own automobile to perform the duties required under this Agreement and shall keep it maintained and repaired in good driving condition. Applicant shall maintain insurance on the automobile according to minimum amounts specified by the State of Indiana. Applicant certifies by signing below that they currently have and will continue to maintain legal automobile coverage while employed with the Agency and using their car to transport Agency clients.

## Release from Liability:

In consideration of working on an Agency assignment, Applicant assumes all risk of accidents or casualties, arising from or related in any way to automobile use by Applicant pursuant to this Agreement. Applicant, Applicant's heirs, executors, administrators and legal representatives, forever releases, acquits and discharges the Agency from all such claims for liability of any nature or character, including property damage, applicant injury and/or death, presented by any applicant(s) claiming injury, including Applicant or agency's clients. In addition, Applicant certifies by signing this agreement that they will not drive an Agency client's vehicle without having the client sign an Agency liability waiver.

In witness of the above, each part to this agreement has caused it to be executed in Indiana on the date indicated below.

**Witness:**

**Applicant:**

\_\_\_\_\_  
**Signature and Title**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

## EMPLOYEE CONSENT FOR INSURANCE VERIFICATION

To Whom it May Concern:

I give \_\_\_\_\_, my insurance broker, authorization to release to my employer the following information:

1. Automobile insurance policy information.
2. Copies of automobile policies and certificates of insurance.

I also give authorization to advise my employer of any changes in my automobile insurance.

I am aware and acknowledge the information referred to above is not shared with any third parties except the employer if requested at any time for audit. The information is used by the employer to confirm adequate and proper insurance coverage of my automobile while being used during the course of my employment. By signing below, I give the employer consent to collect the information contained herein and use for the purpose specified. By signing below, I also give my consent to my insurance broker to provide the employer with above-mentioned information.

SIGNATURE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

## STATEMENT OF DRIVING STATUS

**CHECK ONE OPTION BELOW:**

I, \_\_\_\_\_, am currently licensed to drive a motor vehicle in the state of INDIANA,

I carry auto insurance on my vehicle, and I have supplied Signal Health Group, Inc. a current copy of my license and auto insurance.

I, \_\_\_\_\_, declare that I do not have a driver's license in the state of INDIANA and therefore will find other forms of transportation to get to my scheduled visits (i.e. public transportation).

---

Signature

---

Date

## AVAILABILITY LIST

EMPLOYEE NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DOH: \_\_\_\_\_

AVAILABLE	FROM	TO
Mon		
Tues		
Weds		
Thurs		
Fri		
Sat		
Sun		

List towns you are willing to travel to:

## APPLICANT AUTHORIZATION FOR DIRECT DEPOSITS

SIGNAL HEALTH GROUP, INC.

This authorizes Signal Health Group to send credit entries electronically, or by any other commercially accepted method, to my (our) account(s) indicated below, and to other accounts I (we) identify in the future. This authorizes the financial institution holding the account to post all such entries.

ACCOUNT TYPE:

Checking

Savings

BANK NAME: \_\_\_\_\_ BRANCH: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

BANK ROUTING # (ABA #): \_\_\_\_\_

ACCOUNT #: \_\_\_\_\_

This authorization will be in effect until Signal Health Group receives a written termination notice from myself and has a reasonable opportunity to act on it.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

ATTACH VOIDED CHECK HERE



## SOCIAL MEDIA POLICY

At Signal Health Group Inc., we understand that social media can be a fun and rewarding way to share your life and opinions with family, friends and co-workers around the world. However, use of social media also presents certain risks and carries with it certain responsibilities. To assist you in making responsible decisions about your use of social media, we have established these guidelines for appropriate use of social media.

This policy applies to all personnel, direct hire or contracted, who provide care and services on behalf of Signal Health Group Inc. to patients on our service.

To be in compliance of HIPAA regulations, it is the policy of our Agency, that, at no time, shall any type of patient information of any kind, be included in any social media utilized by Agency staff.

### PROCEDURES:

In the rapidly expanding world of electronic communication, social media can mean many things. Social media includes all means of communicating or posting information or content of any sort on the Internet, including to your own or someone else's web log or blog, journal or diary, personal web site, social networking or affinity web site, web bulletin board or a chat room, whether or not associated or affiliated with Signal Health Group Inc. , as well as any other form of electronic communication.

Before creating online content, consider some of the risks and rewards involved. Keep in mind that any of your conduct that adversely affects your job performance, the performance of fellow associates or otherwise adversely affects members, customers, suppliers, people who work on behalf of Signal Health Group Inc. or the legitimate business interests of Signal Health Group Inc. , or violated any HIPAA privacy laws, may result in disciplinary action up to and including termination.

Carefully read these guidelines, our Agency Ethics Policy, HIPAA Information, and Discrimination Policy, and ensure all of your postings are consistent with these policies. The same principles and guidelines found in our policies and three basic beliefs apply to your activities online:

- **BE Fair**
- **BE Respectful**
- **BE Honest**

#### ***Be Respectful***

Inappropriate postings that may include discriminatory remarks, harassment, and threats of violence or similar inappropriate or unlawful conduct will not be tolerated and may subject you to disciplinary action up to and including termination. **Online discrimination and harassment is prohibited.**

#### ***Be Fair***

Always be fair and courteous to fellow associates, customers, members, suppliers or people who work on behalf of Signal Health Group Inc. . Also, keep in mind that you are more likely to resolved work-related complaints by speaking directly with your co-workers or by utilizing our Open Door Policy, than by posting complaints to a social media outlet. Nevertheless, if you decide to post complaints or criticism, avoid using statements, photographs, video or audio that reasonably could be viewed as malicious, obscene threatening or intimidating, that disparage customers, members, associates or suppliers, or that might constitute harassment or bullying or violate any HIPAA laws. Examples of such conduct might include offensive posts meant to intentionally harm someone's reputation or posts

that could contribute to a hostile work environment on the basis of race, sex, disability, religion or any other status protected by law or company policy.

### ***Be Honest & Accurate***

Make sure you are always honest and accurate when posting information or news, and if you make a mistake, correct it quickly. Be open about any previous posts you have altered. Remember that the Internet archives almost everything; therefore, even deleted postings can be searched. Never post any information or rumors that you know to be false about Signal Health Group Inc. , fellow associates, members, customers, suppliers, or people working on behalf of our Agency or competitors. And NEVER about clients or patients of our Agency. To do so is in violation of HIPAA privacy laws.

## **SOCIAL MEDIA GUIDANCE**

**Maintain the confidentiality** of our Agency private & confidential information. This may include information regarding the development of systems, processes, products, know-how and technology and any & all patient information. Do not post internal reports, policies, procedures or other internal business-related confidential communications.

**Respect financial disclosure laws.** It is illegal to communicate or give a “tip” on inside information to others so that they may buy or sell stocks or securities. Such online conduct may also violate the Insider Trading Policy.

**Do not create a link** from your blog, website or other social networking site to a Signal Health Group Inc. website without identifying yourself as a Signal Health Group Inc. associate.

**Express only your personal opinions.** Never represent yourself as a spokesperson for Signal Health Group Inc. . If our Agency is a subject of the content you are creating, be clear and open about the fact that you are an associate and make it clear that your views do not represent those of Signal Health Group Inc. , fellow associates, members, customers, suppliers or people working on behalf of our Agency. If you do publish a blog or post online related to the work you do, make it clear that you are not speaking on behalf of Signal Health Group Inc. . It is best to include a disclaimer such as “The postings on this site are my own and do not necessarily reflect the views of Signal Health Group Inc..”

**Refrain from using social media while on work time** or on equipment we provide, unless it is work-related as authorized by your manager or consistent with the Company Equipment Policy. Do not use Signal Health Group Inc. email addresses to register on social networks, blogs or other online tools utilized for personal use.

**Retaliation is prohibited.** Signal Health Group Inc. prohibits taking negative action against any associate for reporting a possible deviation from this policy or for cooperating in an investigation. Any associate who retaliates against another associate for reporting a possible deviation from this policy or for cooperating in an investigation will be subject to disciplinary action, up to and including termination.

**Media contacts.** Associates should not speak to the media on Signal Health Group Inc. 's behalf without contacting the Administrator. All media inquiries should be directed to them.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## **DRESS CODE**

Employee dress should be neat in appearance. Our Agency employees are invited to dress “business casual” in a manner consistent with a professional atmosphere. The impression made on customers, visitors and other employees and the need to promote company and employee safety should be kept in mind.

Our Agency requires it's field staff to wear scrubs. Scrubs both present a professional “medical” image and protect your good clothes from damage and/or wear. Our Agency does not replace clothing damaged from normal on the job usage while providing home care services to our patients.

All field staff must wear their Agency picture ID badge on their person while making home visits. Should your ID be lost or damaged it is your responsibility to come to the office for a replacement.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## **SEXUAL HARASSMENT**

Our Agency will not allow any form of sexual harassment within the work environment.

Sexual harassment interferes with work performance and creates an intimidating, hostile or offensive work environment. Sexual harassment influences or tends to affect the career, salary, working conditions, responsibilities, duties or other aspects of career development of an employee or prospective employee. It will not be tolerated.

Sexual harassment, as defined in this policy, includes, but is not limited to, sexual advances, verbal or physical conduct of a sexual nature, visual forms of a sexual or offensive nature (e.g., signs and posters) or requests for sexual favors.

Any intentional sexual harassment is considered to be a major violation of company policy and will be dealt with accordingly by corrective counseling and/or suspension or termination, depending upon the severity of the violation.

- **Sexual Abuse/Harassment:** Our Agency prohibits and has a zero tolerance Policy for sexual abuse in the workplace or in any organizational related activity by anyone associated in any way with the Agency. The organization provides procedures for employees, volunteers, family members, board members, patients, victims of sexual abuse, or others to report sexual abuse and disciplinary penalties for those who commit such acts. No employee, volunteer, patient or third party, no matter his or her title or position has the authority to commit or allow sexual abuse.

**Reporting of Suspected Sexual Abuse:** If you are aware of or suspect sexual abuse taking place, it must be immediately reported to the Administrator or another person designated such as a human resource person. If the suspected abuse is to an adult, it shall be reported to the state Adult Protective Services Agency. If it is a child who is the victim it should be reported to the state Child Abuse Agency or you can call the Child Help's National Child Abuse Hotline, 1-800-422-4453. Appropriate family members should be notified of alleged instances of sexual abuse.

The Agency shall also report the alleged sexual abuse incident to their insurance agent.

## **ANTI-RETALIATION**

Signal Health Group Inc. prohibits retaliation made against any employee, volunteer, board member or patient who reports a good faith complaint of sexual abuse or who participates in any related investigation. Making false accusations of sexual abuse in bad faith can have serious consequences for those who are wrongly accused. Our Agency prohibits making false and/or malicious sexual abuse allegations, as well as deliberately providing false information during an investigation. Anyone who violates this rule is subject to disciplinary action, up to and including termination.

### **Investigation and Follow Up:**

Signal Health Group Inc. will take all allegations of sexual abuse seriously and will promptly and thoroughly investigate whether sexual abuse has taken place. The organization will use an outside third party to conduct an investigation. If the organization has a trained internal investigation team in place, the team will be used to investigate the incident. We will cooperate fully with any investigation conducted by law enforcement or other regulatory agencies. It is the organization's objective to conduct a fair and impartial investigation. The Agency provides notice that they have the option of placing the accused on a leave of absence or on a reassignment to non-patient contact.

The organization will make every reasonable effort to keep the matters involved in the allegation as confidential as possible while still allowing for a prompt and thorough investigation.

## **ILLEGAL DRUG ABUSE / ALCOHOL ABUSE**

This policy is implemented because we believe that the impairment of any of our Agency's employees, due to his or her use of illegal drugs or due to alcohol abuse, is likely to result in the risk of injury to patients, other employees, the impaired employee, or to third parties, such as customers or business guests. Moreover illegal drug abuse adversely affects employee morale and productivity.

"Impairment" or "being impaired" means that an employee's normal physical or mental abilities or faculties while at work have been detrimentally affected by the use of illegal drugs or alcohol.

The employee who begins work while impaired or who becomes impaired while at work is guilty of a major violation of company rules and is subject to severe disciplinary action. Severe disciplinary action can include suspension without pay, dismissal or any other penalty appropriate under the circumstances. Likewise the use, possession, transfer or sale of any illegal drugs on company premises or in any Agency storage area or job site is prohibited. Employees who violate this rule are subject to severe disciplinary action including termination. In all instances disciplinary action to be administered shall be at the sole discretion and determination of the company.

When an employee is involved in the use, possession, transfer or sale of illegal drugs in violation of this policy, the company may notify appropriate authorities. Such notice will be given only after such an incident has been investigated and reviewed by the employee's supervisor and the HR director. Our Agency is aware that illegal drug abuse is a complex health problem that has both physical impact and an emotional impact on the employee, his or her family, and social relationships. A drug abuser is a person who uses illegal drugs, as defined above, for non medical reasons, and this use affects job performance detrimentally or interferes with normal social interaction at work. Illegal drug abuse is both a management and a medical problem.

A supervisor/manager who suspects a drug or alcohol abuse case should discuss the situation immediately with his or her Administrator. Because each case is usually different, the handling and referral of the case must be coordinated with the supervisor/manager and the personnel director.

Applicants who have a past history of substance abuse (SA) and who have demonstrated an ability to abstain from the substance, or who can provide medical assurance of acceptable control, may be considered for employment as long as they are otherwise qualified for the position for which they are applying. The Home Health setting is more problematic for past/present history of SA as elders frequently have many medications in their home and Home Health workers generally are alone in the home with the patient increasing the temptation factor. Due to this aspect of our industry, our Agency must have more than the usual "medical assurance of control" over SA. Our Agency will not schedule a worker with a history of SA for 6 months after "medical assurance of control" over SA is received by our office. In this case, the employee enters an unpaid leave of absence status until the 6 month benchmark is achieved. The assignment of cases at this point will occur once a second "continued medical assurance of control" over SA is received by the employee's private MD. Our Agency does not pay for medical care to achieve the status of "medical assurance of control" over SA.

Management has chosen to adopt an alcoholic beverage policy in keeping with the concern for and the risks associated with alcohol use. Alcoholic beverages shall not be served or used on the Agency's premises at any time. Alcoholic beverages shall not be used in conjunction with any company business meeting. Our Agency enforces strict policy related to alcohol and its patients:

1. employee may not purchase alcohol for any patient of any age group
2. employee may not engage socially with an Agency patient at a function where alcohol is being served
3. employee may never function in the capacity of "designated driver" for a patient

Social activities held off-premises and paid for on a personal basis are not affected by this policy. If management considers it appropriate, light alcoholic beverages may be served at company-sponsored events held off-premises and for purely social reasons. The service must be managed in good taste and with good judgment.

The company is concerned with its employee's privacy, especially when matters regarding medical and personal information are involved. As long as the information is not needed for police or security purposes, the company shall maintain employee medical and personal information in confidence and release this information to authorized company personnel on a "need to know" basis. An exception to this policy is when the employee signs a release for the transfer of such information on forms acceptable to the company to designated persons or agencies.

Nothing contained in this section shall eliminate or modify the company's right to terminate any employee at any time for any reason.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## 1.2 Calling Tree Protocol for Emergency Events

Policy Number: EP: 1.2

Effective Date: 1/2019

### POLICY:

As part of our Agency Emergency Preparedness Plan, our Agency will create & maintain an Agency Calling Tree to be utilized should our Emergency Preparedness Plan be activated.

### PROCEDURE:

The Emergency Disaster Coordinator will oversee the creation of the Agency Emergency Calling Tree.

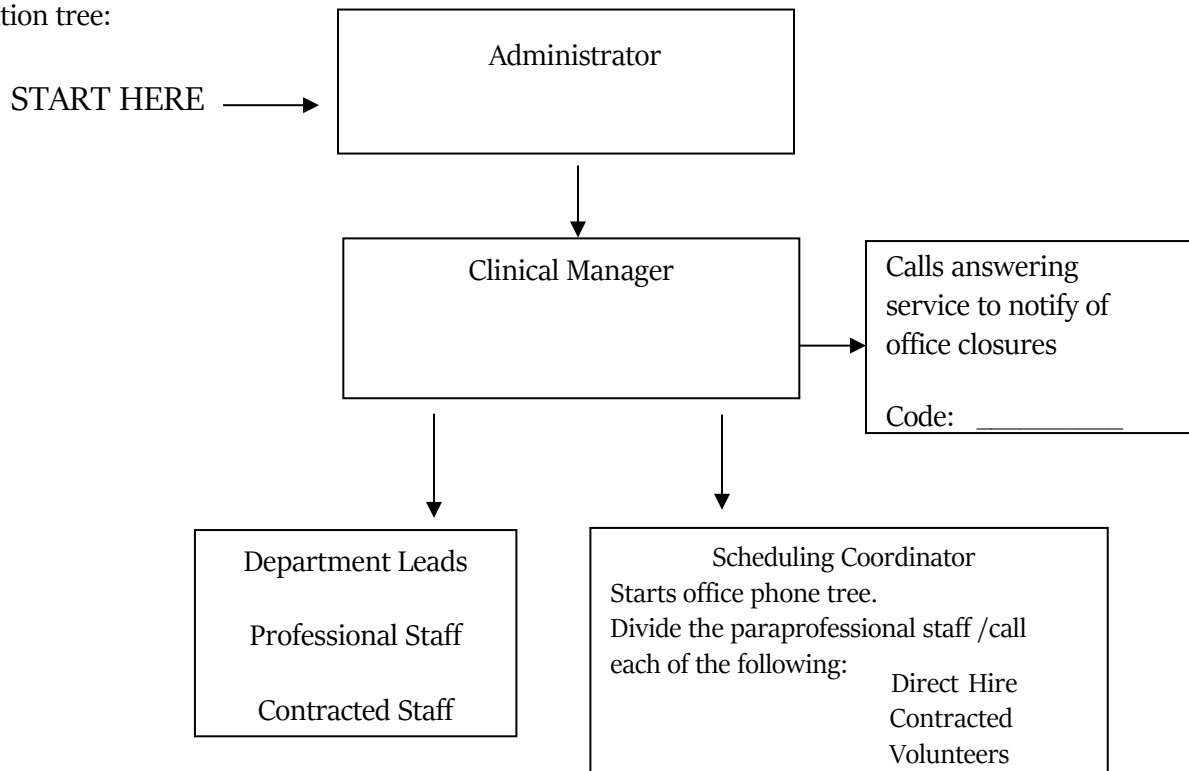
The calling tree will be part of the Agency Emergency Preparedness Plan and be updated at least annually or as needed.

### Signal Health Group Inc. Emergency Calling Tree

The Administrator makes the decision to close offices due to emergency situation.

Weather and Other Emergencies:

Notification tree:



EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_