Active HOME HEALTHCARE, LLC	Date Name: Location: Availability: Language:

All Applications must have:

1. Driver's License
2. Green Card or Proof of American Citizenship
3. Social Security Card
4. PCA Certification or CNA License
5. Valid CPR card (Online CPR class is not acceptable)
6. TB Test-Negative result-12 months or less/ Clear Chest X-ray result-5 years or less

Application for Employment

PERSONAL DATA

Date Application Completed	OFFICE USE ONLY Date of Interview	OFFICE USE ONLY Date of Hire
Last:	First	Middle

Social Security Number	Home Phone ( )	Other Number ( )	Cellular Number ( )

Address *(If less than one year provide your previous address)*	City	State	Zip Code	Length of Residence
Previous Address	City	State	Zip Code	Length of Residence

JOB INTERESTS

Position Applying For:	How were you referred to us?	Date Available for Work?	Anticipated Wage

Please check the specialty area(s) that best match(es) your experience / education and interested

☐ Homecare	☐ Medical / Surgical	☐ IV Therapy	☐ Intermittent Care	☐ Private Duty
☐ Hospice	☐ Rehabilitation	☐ Pediatrics/Maternal Child	☐ Supplemental Staffing	☐ Residential Care
☐ Nursing Home	☐ Hospital	☐ Geriatric	☐ Psychiatric	☐ Homemaking

Please indicate your availability or interests below

Work Status
☐ Full Time (32 hours per week average)
☐ Part Time (less than 32 hours per week average)

Shifts Available
☐ Days ☐ Evenings
☐ Nights ☐ Visits Only

Days Available
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday
☐ Friday ☐ Saturday ☐ Sunday

EDUCATION

Circle the Highest level of education completed	1 2 3 4 5 6 7 8 9 10 11 12 High School Diploma Associate Bachelors Masters	
Name of College or Undergraduate Education / School	Degree	Year Graduated
Name of College or Undergraduate Education / School	Degree	Year Graduated

LICENSE / CERTIFICATIONS / EXAMINATIONS

Type of License	State of Issue	Expiration Date	License Number	Any restrictions or pending actions against license?

CPR Expiration	Last Physical Examination	Last TB/Chest X-ray

GENERAL INFORMATION

Are you legally authorized to work in the USA	☐ Yes	☐ No	If you become an employee of this Agency you will be required to provide documentation proving your eligibility to work in the USA
Have you ever been convicted or plead guilty of a felony or a misdemeanor crime?	☐ Yes	☐ No	If Yes –explain:
Have you ever been employed by this agency or one of its subsidiaries	☐ Yes	☐ No	If yes, give location and dates:

In case of emergency, notify	Phone	Relationship

WORK HISTORY

Company Name (present or most recent employer)		Employment Dates			
		From:		To:	
Company Address	City	State	Wage Per Hour Annual		
Describe your Job Responsibilities and Duties					
Supervisor's Name	Telephone Number	May We Contact ☐ Yes ☐ No			
Reason for Leaving?					

Company Name		Employment Dates			
		From:		To:	
Company Address	City	State	Wage Per Hour Annual		
Describe your Job Responsibilities and Duties					
Supervisor's Name	Telephone Number	May We Contact ☐ Yes ☐ No			
Reason for Leaving?					

Company Name		Employment Dates			
		From:		To:	
Company Address	City	State	Wage Per Hour Annual		
Describe your Job Responsibilities and Duties					
Supervisor's Name	Telephone Number	May We Contact ☐ Yes ☐ No			
Reason for Leaving?					

Company Name		Employment Dates			
		From:		To:	
Company Address	City	State	Wage Per Hour Annual		
Describe your Job Responsibilities and Duties					
Supervisor's Name	Telephone Number	May We Contact ☐ Yes ☐ No			
Reason for Leaving?					

In accordance with Title VI of the Civil Rights Act of 1964 and its implementing regulation, Active Home Healthcare LLC. is an EQUAL OPPORTUNITY EMPLOYER and WILL NOT DISCRIMINATE AGAINST RACE, COLOR, SEX, CREED, NATIONAL ORIGIN OR COMMUNICABLE DISEASE AS DEFINED IN SECTION 504 OF TITLE VI. In accordance with Section 504 of the Rehabilitation Act of 1973 and its implementing regulation Active Home Healthcare LLC. WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF HANDICAP. In accordance with the Age Discrimination Act of 1975 and its implementing regulation, Active Home Healthcare LLC. WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF AGE in the provision of services, unless age is a factor necessary to the normal operation or the achievement of any statutory objective. In accordance with the Americans with Disabilities Act of 1992 (42 USC §12101) and its implementing regulations, (private employers with more than 25 agency personnel), Active Home Healthcare LLC, WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF DISABILITY. A disability is a physical or mental impairment that substantially limits a major life activity, or for which there is a record of impairment or which causes the individual to be regarded as impaired.

The information that I have given is true and accurate to the best of my knowledge

Signature of Applicant	Date

Tel: 703-855-7193 Fax:

Professional Reference Form

Reference For: _____
Name:_____ Reference Phone Number:_____

1. How long have you known the applicant?
   a. Personally: _____
   b. Professionally:_____

2. What has been your professional relationship with the applicant?
   Employer
   Coworker
   Supervisor
   Other, Please Specify_____

3. Please indicate your appraisal of the applicant in the following categories:
   a. Personal Honesty: _____
   b. Personal Integrity:_____
   c. Personal Ethics:_____

4. Do you know of any instances where the applicant was convicted of illegal conduct or professional misconduct?
5. Additional information and comments which would amplify or clarify the items above and thus assist the Board in evaluating the applicant's experience and qualifications are strongly requested. Is there anything else you would like to add?

_____
_____
_____
_____

Interviewed By: _____
Date Interviewed: _____

Tel: 703-855-7193 Fax:

Professional Reference Form

Reference For: _____
Name:_____Reference Phone Number:_____

1. How long have you known the applicant?
   c. Personally: _____
   d. Professionally:_____

2. What has been your professional relationship with the applicant?
   Employer
   Coworker
   Supervisor
   Other, Please Specify_____

3. Please indicate your appraisal of the applicant in the following categories:
   d. Personal Honesty: _____
   e. Personal Integrity:_____
   f. Personal Ethics:_____

4. Do you know of any instances where the applicant was convicted of illegal conduct or professional misconduct?

5. Additional information and comments which would amplify or clarify the items above and thus assist the Board in evaluating the applicant's experience and qualifications are strongly requested. Is there anything else you would like to add?

_____
_____
_____
_____

Interviewed By: _____
Date Interviewed: _____

(I give permission for Active Home Healthcare LLC to contact previous employers for information about me)

Tel: 703-855-7193 Fax:

EMPLOYMENT REFERENCE REQUEST

(Contact current employer only with permission of applicant)

A former employee has applied for a position with our organization and has authorized us to obtain a reference from you. We would appreciate you completing and returning this form to us your earliest convenience.

Applicant Last Name:_____ First Name:_____ Middle Name:_____

Social Security:_____ Employed From:_____ To :_____ Separation Reason:_____

(I give permission for Active Home Healthcare LLC to contact previous employers for information about me)

Applicant's Name:_____ Signature:_____ Date: _____

Active Home Healthcare LLC representative (print name): _____
Date: _____

……..THIS SECTION TO BE COMPLETED BY EMPLOYER……

Performance	Excellent	Good	Satisfactory	Fair	Poor
How well did applicants get along with management and co-worker?					
Rate the applicant's professional behavior while working for you?					
Rate the applicant's overall attendance and Dependability.					
How well does the applicant cooperate?					
Rate how this applicant handled difficult issues.					
Rate how this applicant's overall productivity, and customer orientation					
Rate your overall assessment of this applicant					

Reason for applicant's separation from your company

_____

If given the opportunity, would you rehire this applicant? Yes:_____ No: _____

Additional Comments:

_____

_____

Organization:_____ Phone # _____

Completed by (print name):_____ Title (print): _____
Signature:_____ Date: _____

Active Home Healthcare LLC.,

NON-COMPETE AGREEMENT

As an employee of Active Home Healthcare LLC, the employee acknowledges that they will be in receipt of confidential information. This information includes but not be limited to, procedures manuals, in-house policies, patient lists, patient's medical records, financial information and billing records, certifications and applications, actual and prospective markets a patient's, business plans and marketing strategies, customer lists, sales and marketing data, operating systems, income statements, asset and liability information, financial projections and any other confidential information gathered, revealed, acquired or generated by or for Active Home Healthcare LLC, . Each employee shall protect and hold in confidence the confidential information to anyone except with the express written consent of (Tiwaunda Joseph). The employee acknowledges and understands the competitive sensitivity of the confidential information and potential for significant material harm that could result to Active Home Healthcare LLC, in the event that confidential information is disseminated to others, in particular competitors. Therefore, the employee agrees that the appropriate remedy would be an immediate injunction against the violating employee in joining and prohibiting the use and continued dissemination of the confidential information. Further, each employee agrees that the dissemination of the confidential information would cause damages for which damages could not be readily ascertained and would constitute a breach of duty owed by the employee to Active Home Healthcare LLC, Each employee agrees to pay Active Home Healthcare LLC, in any action to enforce this confidentiality agreement or cost of litigation, including attorney's fees and other damages found by the Trier of fact.

As consideration for employment and for the release of this confidential information, employees agree not to compete against Active Home Healthcare LLC, or to utilize any of the confidential information for a period of two (2) years from the date of their employment terminated with Active Home Healthcare LLC,. This Non-Compete Agreement shall be limited to (Prince William County) and contiguous counties. This Non-Compete Agreement is not intended to prohibit employee from working as a nurse, therapist or other position in the health service industries but is intended to prohibit employee from working with a competitor of Active Home Healthcare LLC, in the home health industryand utilizing any of the confidential information of Active Home Healthcare LLC or contacting any of Active Home Healthcare LLC, patients,. Employee agrees and warrants that they will contact, engage, discuss, negotiate or contract with any patient or family member of a patient for those confidential information is of a proprietary nature to Active Home Healthcare LLC, and if the confidential information was revealed to the general public or to a competitor, the revelation would destroy or impair the expected success of Active Home Healthcare LLC,.

ANY CONTROVERSY OR CLAIM ARISING Or OF OR RELATING TO THIS AGREEMENT SHALL BE SUBMITTED TO ARBITRATION BEFORE ONE (1) ARBITRATOR IN (Fairfax, VA),
IN ACCORDANCE WITH THE COMMERCIAL ARBITRATION RULES OF THE AMERICAN ARBITRATION ASSOCIATION JUDGEMENT UPON THE AWARD RENDERED BY THE ARBITRATOR MAY BE ENTERED BY ANY COURT HAVING JURISDICTION THEREOF ARBITRATION SHALL CONTROVERSY BETWEEN Active Home Healthcare LLC, AND EMPLOYEE ARISING FROM THIS AGREEMENT

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

Employee Name	*Date*
Agency Representative	*Date*

Tel: 703-855-7193, Fax:

SWORN STATEMENT OF AFFIRMATION
Please Print

Last Name _____ First _____ Middle _____ Social Security Number _____

Current Mailing Address _____ Street, P.O. Box Box #, Apt# _____ City _____ State _____ Zip Code _____

_____
Name of the Agency Street, P.O. Box Box #, Apt# City State Zip Code

Please respond to all the questions:

Have you ever been convicted of or are you subject of pending changes of any crime within the Commonwealth of Virginia?
☐ Yes (Convicted in Virginia); ☐ Yes (Pending in Virginia); ☐ No (if yes or Pending, Specify Crime(s):

_____

☐ Yes (Convicted in outside Virginia); ☐ Yes (Pending in outside Virginia); ☐ No (if yes or Pending, Specify Crime(s) and State, or other location:

_____

Have you ever been subject of a founded complaint of child abuse or neglect within the Commonwealth of Virginia?
☐ Yes (in Virginia); ☐ No (in Virginia); ☐ Yes (outside Virginia); ☐ No (outside Virginia); ☐ If yes or pending, specify state, or other location:

_____

I am hereby affirm that the information provided on this form is true and complete. I understand that the information is subject to verification and that making materially false statements or affirmation is class 1 misdemeanor.

_____ _____
Signature *Date*

Tel: 703-855-7193 Fax:

To: Active Home Healthcare LLC, EMPLOYEES (new & re-turned employee)

Regarding: DOCUMENTS VERIFICATION

Upon completing your application, please provide us a copy of the following documents for your job verification process:

- Valid Driver's License
- U.S Citizenship, U.S Passport, U.S. Birth Certificate, U.S. Voting Card, or valid Permanent Resident/Green Card
- Social Security Card
- Valid RN License, Valid LPN License, Valid CAN License, or PCA Certification
- Valid CPR card (Note: online CPRs are not acceptable)
- TB Test Result – Negative (12 months or less) or Chest X-ray Result – Clear (5 years or less)

Before you start your employment at Active Home Healthcare LLC, it is your responsibility that we receive all documents listed above to be on file. Failure to turn in any of the documents after you start working, your paychecks will be on hold until all of the documents listed are received by the HR department. Please also note it is your responsibility that you keep track of all your documents expiration dates and have them renewal before expired as well as have them submitted to the office HR department before receiving pay checks

This letter serves as an official agreement that you will comply with the agency's regulations regarding work documentations and compliance upon employment with Active Home Healthcare LLC, A copy of this letter will be placed in your permanent personal file in the Human Resource Services. Please sign in the space provided below to acknowledge that you understand our policy of hiring and that you received a copy for yourself.

Employee Name *Employee Signature* *Date*

Sincerely,

Human Resources Department
Active Home Healthcare LLC.,

Tel: 703-855-7193 Fax:

To: Active Home Healthcare, LLC; EMPLOYEES (new & returned employees)

Subject: Electronic Visit Verification (EVV) for Timesheets AND PAYROLL PROCESSING RULES

Per Medicaid rule Section 12006(a) of the 21st Century Cures Act mandates that states implement EVV **(Electronic Visit Verification)** for all Medicaid personal care services (PCS) and home

health services (HHCS). Thus; Active Home Healthcare LLC payroll process requires all timesheets to be entered daily at the client home via Electronic Visit Verification (EVV) application and can no longer accept old TIMESHEETS formats in paper.

We expect all of our employees to follow the Medicaid rule and enter their work hours on a daily basis at the client's premises- Note, this requires both signing-in at the beginning of the shift and signing-out at the end of the shift.

Work hour entries with errors or inaccurate information will not be filed which will result in no payment to both the Agency-Active Home Healthcare LLC and the employee. As a courtesy Agency Timesheet processor may call to inform employees of errors if time permits, otherwise it is the employee's responsibility to enter their daily work hours accurately, correctly, and punctually.

- No work Entry = NO PAY Late Work Entry = No PAY for hours not entered
- Work *Entries* are due at the beginning and end of each work shift- no excuses!!!
- Work Entries are fully the RESPONSIBILITY of the EMPLOYEE. Please Note: Agency can only file work hours submitted correctly and accurately.

I_____have read and fully understand the timesheet and payroll process. I do not have any questions about the process. I agree to the scheduling deadlines and will follow this policy. I understand that my payments will be on hold or late if I do not turn-in my timesheet on time or do not follow Active Home Healthcare LLC, regulations regarding timesheets and payroll process. If I have any questions or concerns in the future, I will contact my manager at the office.

_____ _____ _____

Employee Name *Employee Signature* *Date*