The Sun Home Health

We Believe In Excellence! - Since 1997

APPLICATION FOR EMPLOYMENT

Last Name	First Name	Middle Name
Street Address		
City	State	Zip code ☐☐☐☐☐
Home Phone	Cell Phone	S.S.No.
Email Id		Date of Birth
Have you ever filled out an application with us before?		☐ No ☐ Yes, on Date
Have you ever been employed with us before?		☐ No ☐ Yes, on Date
Have you ever been convicted of a felony?		☐ No ☐ Yes, Please explain
Have you taken any illegal drugs within the last 30 days?		☐ No ☐ Yes
Have you ever been fired or forced to resign?		☐ No ☐ Yes, Please explain
Have you reveived disciplinary action within the last 12 months of active employment?		☐ No ☐ Yes, Please explain
Are you legally permitted to work in the United State?		☐ No ☐ Yes
Education		
Position for which you are applying	Expected Compensation	
Are you aware of the qualifications for this job?		☐ No ☐ Yes
Do you meet the qualifications for this job?		☐ No ☐ Yes
Are you aware of the essential functions for this job?		☐ No ☐ Yes
Can you perform these essential functions either with or without reasonable accommodations?		☐ No ☐ Yes
Name and address of high school		
Major course of study		
Degree or certificate earned		

Name and address of undergraduate or graduate school

Name and address of vocational school, technical school, hospital or other school

Administrative Skills

- ☐ Computer and Software
- ☐ Typing at ( ) WPM
- ☐ Multi-line telephone system
- ☐ Microsoft Word
- ☐ Microsoft Excel or other spreadsheet Program

Additional Experience

Employee Emergency Contact Information

Please provide personal contacts to whom we may get in touch as a professional reference for employment or in an emergency situation.

Contact(s)	Name	Phone No	Relationship	Office Use Only
Emergency Reference				
Emergency Reference				
Emergency Reference				

Employment History

Begin with your most recent job when listing previous employers. Include any job related to military service assignments and volunteer activities. You may exclude organizations which indicate race, color, religion, gender, national origin, disabilities or other protected status.

Reference checking is an integral part of our hiring process.
May we contact your pervious employers and personal references? ☐ No ☐ Yes

Employer #1 Name and address		
Supervisor Name		Supervisor's Number
Dates employed		Job Title
Work performed		
Reason for leaving		
Office Use only	Employee	Staff Contacted
	Contact Date	Termination due to
	Method	Would re-hire
	Comments	
Employer #2 Name and address		
Supervisor Name		Supervisor's Number
Dates employed		Job Title
Work performed		
Reason for leaving		
Office Use only	Employee	Staff Contacted
	Contact Date	Termination due to
	Method	Would re-hire
	Comments	
Employer #3 Name and address		
Supervisor Name		Supervisor's Number
Dates employed		Job Title
Work performed		
Reason for leaving		
Office Use only	Employee	Staff Contacted
	Contact Date	Termination due to
	Method	Would re-hire
	Comments	

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Application Form Waiver

In exchange for the consideration of my job application by The Sun Home Health Companies (hereafter called "the company"), I agree that (please review and initial next to each section):

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position for which I have applied or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements, and the like as they may exist from time to time, or the company's practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of the company, otherwise to change in any respect the employment-at-will relationship between the company and the undersigned, and that relationship cannot be altered except by a written instruction signed by the President/General Manager of the company. Both the undersigned and the company may end employment relationship at any time, without specified notice or reason. If employed, I understand that the company may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the mis-representation or omission of facts called for its cause for dismissal at any time without any previous notice. I hereby give the company permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release the company from any liability as a result of such contract.

I understand that the company has a criminal background check policy that provides for pre-employment screening. I consent to and will comply with such policy as a condition of my employment. I understand that my employment will be based on the successful passing of screening under such policy. I further understand that continued employment may be based on the successful passing of job-related physical examination, skills evaluation examinations, and or training program.

I understand that my employment with the company shall be probationary for a period of ninety (90) days, and that at any time during the probationary period or thereafter, my employment is terminable at-will for any reason by either party. During my probationary period, benefits and other employee privileges may not be available to me.

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I hereby authorize any person, educational institution, or company I have listed as a reference on my employment application to disclose in good faith any information they may have regarding my qualifications and fitness of employment. I will hold the company, any former employers, educational institutions, any other persons giving references free of liability for the exchange of this information and any other reasonable and necessary to the employment process.

I certify that the answers given herein are true and complete to the best of my knowledge. If I am employed, I understand that false or misleading information given in my application or interview(s) may result in termination of my employment with the company. I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision. If my signature is needed to investigate statements contained in this application or to check my references, a photocopy of my signature may be used instead of the original.

If I am employed, I understand that I will be required to abide by all rules and regulations of the company. I further understand that, unless otherwise defined my applicable law, any employment relationship with this organization is of an "at will" nature. This means that the employee may resign at any time and the employer may discharge employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of the company.

"I acknowledge and agree that because Agency invests time and money in the process of hiring staff and personnel, I will not seek work at any customer of Agency, under any conditions, until my employment with Agency has terminated for at least one year. I further agree that I will not solicit any Agency employee to leave Agency employment.

I further acknowledge and agree that I will not seek or accept employment in any capacity from any customer of Agency for at least 180 days from the last day of that assignment."

I hereby acknowledge

Name Date

Address

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Information Use and Disclosure

I give my permission to share the information requested in this application for The Sun Home Health Companies with the companies listed below. I understand that, if hired, I will be considered an employee of each company and that my information will be kept on file in multiple locations as a valid application for each company. I understand that I will get separate paychecks for each company from which I accept patients.

The Sun Home Heath, Inc
The Sun Home Health Care, Inc
The Sun Home Health Care at Columbus, Inc

Equal Employment Opportunity Employer

The company is an equal employment opportunity employer and service provider. The Sun Home Health Companies offer equal employment opportunity to all job applicants and gives all employees equal consideration in employment practices. The Sun Home Health Companies do not discriminate on the basis of race, color, religion, national origin, sex, age, disability, or ancestry. Additionally, it is our policy to provide promotion and advancement opportunities in a non-discriminatory fashion.

Thank you for completing this application and for your interest in our company.

I hereby acknowledge

Name **Date**

Address

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Policy on Confidentiality of Administrative and Patient Information

The Sun Home Health Companies (hereafter called "the company") shall hold in confidence all records and any other healthcare information that personally identifies an individual patient. Information that personally identifies an individual patient shall not be disclosed, unless such disclosure is permitted by law or had been authorized by the patient.

In circumstances requiring patient authorization for the disclosure of information that personally identifies a patient, authorization shall be written, electronic or such other form which indicates the patient's consent.

Information and data that does not personally identify patients may be used for reporting and analyzing. This information may also be made available to third parties, including clients, insurers, research organizations and pharmaceutical manufacturers.

The company has established strong and effective administrative and technical safeguards to protect the confidentiality of any administrative and other personally identifiable patient information and to prevent unauthorized or improper access to, disclosure from, or use of the same.

All employees of the company shall adhere to this policy to protect the confidentiality of personally identifiable administrative and patient information.

I hereby acknowledge

Name **Date**

Address

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Code of Ethics

Ethical, Professional, Respectful and Legal Service Standards
Requirements for Providers to Become, and to Remain, Certified
OAC 173-39-02 (B)(8)
Updated 7/1/19

The provider shall not engage in any unethical, unprofessional, disrespectful, or illegal behavior including the following:

(a) Consuming alcohol while providing services to the individual.

(b) Consuming medicine, drugs, or other chemical substances in a way that is illegal, unprescribed, or impairs the provider from providing services to the individual.

(c) Accepting, obtaining, or attempting to obtain money, or anything of value, including gifts or tips, from the individual or his or her household or family members.

(d) Engaging the individual in sexual conduct or in conduct a reasonable person would interpret as sexual in nature, even if the conduct is consensual.

(e) Leaving the individual's home when scheduled to provide a service for a purpose not related to providing the service without notifying the agency supervisor, the individual's emergency contact person, any identified caregiver, or ODA's designee.

(f) Engaging in any activity that may distract the provider from providing services, including the following:

(I) Watching television, movies, videos, or playing games on computers, personal phones, or other electronic devices whether owned by the individual, provider, or the provider's staff.

(ii) Non-care-related socialization with a person other than the individual (e.g., a visit from a person who is not providing care to the individual; making or receiving a personal telephone call; or, sending or receiving a personal text message, email, or video).

(ii) Providing care to a person other than the individual.

(iv) Smoking tobacco or any other material in any type of smoking equipment, including cigarettes, electronic cigarettes, vaporizers, hookahs, cigars, or pipes.

(v) Sleeping.

(g) Engaging in behavior that causes, or may cause, physical, verbal, mental or emotional distress or abuse to the individual including publishing photos of the individual on social media without the individual's written consent.

(h) Engaging in behavior a reasonable person would interpret as inappropriate involvement in the individual's personal relationships.

Ethical, Professional, Respectful and Legal Service Standards Requirements for Providers to Become, and to Remain, Certified OAC 173-39-02 (B)(8) Updated 7/1/19

(I) Making decisions, or being designated to make decisions, for the individual in any capacity involving a declaration for mental health treatment, power of attorney, durable power of attorney, guardianship, or authorized representative.

(j) Selling to, or purchasing from, the individual products or personal items, unless the provider is the individual's family member who does so only when not providing services.

Requirements to Remain an ODA Certified Agency and Non-Agency Provider OAC 1733902 D)(1)(b) & (D)(2)(b)

The provider shall not engage in the following behaviors in addition to those in paragraph (B)(8):

(i) Consuming the individual's food or drink, or using the individual's personal property without his or her consent.

(ii) Bringing a child, friend, relative, or anyone else, or a pet, to the individual's place of residence.

(iii) Taking the individual to the provider's business site, unless the business site in an ADS center.

(iv) Discussing religion or politics with the individual and others while providing services.

(v) Discussing personal issues with the individual or any other person while providing services.

(vi) Engaging in behavior constituting a conflict of interest, or taking advantage of, or manipulating services resulting in an unintended advantage for personal gain that has detrimental results to the individual, the individual's family or caregivers, or another provider.

(Employee's Signature) (Date)

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HIPAA Orientation

Health Insurance Portability and Accountability Act

It is the policy of The Sun Home Health Companies to ensure that all staff and interdisciplinary team members provide confidentiality for the client's clinical records. Potential patients may avoid treatment or choose to not report a health issue because they are concerned about the privacy of their information. Also, we believe that protecting the privacy of our patients honors our commitment to honesty and respect.

I will adhere to the Agency's Notice of Privacy Practices, and know that this is available to me at all times.

I will maintain knowledge of all areas where Protected Health Information (PHI) is kept in any company office or storage area.

Am aware of the ways PHI is used and disclosed and understand the company policies that relate to the minimum necessary use, requests and disclosure.

I understand that it is every patient's right to keep PHI private.

I understand that I should direct any patient request for restriction on the use/disclosure of their health information to a company privacy official.

I understand that it is my responsibility to ensure that any request for confidential communications documented in every patient's medical record are honored.

I understand that it is my responsibility to ensure that documentation does not include PHI of the patient's family members or other care givers unless essential to the provision of the patients.

I understand how to only use PHI as allowed by The Sun Home Health Companies.

I understand that PHI maintained outside of the medical record for current usage must be protected during the day and locked in file drawers after hours.

I understand that my superior is available at all times to assist in the timely reporting of potential privacy violations to a privacy official, and of my responsibility to do so.

By signing below, I certify :

I have reviewed the HIPAA training and orientation materials.

I will comply with the above listed HIPAA policy regarding every client of The Sun Home Health Companies.

I hereby acknowledge

Name **Date**

Address

Hepatitis B Vaccine

If you wish to receive the Hepatitis B Vaccine, you will need to contact your physician or other health care facility to administer this vaccine. The Sun Home Health Companies (hereafter called "the company") will not administer the vaccine. As such, the company is not responsible for any side effects, allergic reaction or possible harm that might come from receiving this vaccine. The cost of the vaccine will not be covered by the Company.

Please initial next to only one of the following:

☐ **Yes** I have already received the Hepatitis B vaccine at another facility and have included a copy of the results with the submission of my application.

☐ **Yes** I wish to have the Hepatitis B vaccine and will contact a health care facility to have it administered. I understand that I will not be able to visit a patient until I have provided a copy of the results to SHHC.

☐ **NO** I do not wish to have the Hepatitis B vaccine. With my refusal to take the Hepatitis B vaccine, I am agreeing not to hold SHHC liable for any possible contraction of the Hepatitis B disease.

I hereby acknowledge

Name **Date**

Address

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Drug Abuse Policy Statement

The Sun Home Health Companies are committed to providing a safe work environment to foster the well being and health of its employees. That commitment is Jeopardized when any company employee uses illegal drugs or alcohol on the job, comes back to work under the influence, or possesses, distributes, or sells drugs in the workplace. This policy will balance our respect for individuals with the need to maintain a safe, productive and drug-free work environment. The intent of this policy is to offer a helping hand to those who need it, while sending a clear message that the use of illegal drugs or alcohol and impairment from their uses is incompatible with our company goals.

Employees are prohibited from being on company premises at any time under the influence of alcohol or with illegal drugs present in their systems.

In voluntary compliance with the Drug Free Workplace Act of 1988, employees must notify the company of any conviction of a criminal drug violation occurring in the workplace no later than five (5) calendar days of such conviction.

This policy does not prohibit the use of prescription medication taken in accordance with a valid prescription, provided such use does not adversely affect job performance or the safety of the employee or others.

Employees violating this policy are subject to disciplinary action up to and including termination.

I hereby acknowledge

Name **Date**

Address

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BCII Procedure and WebCheck Waiver

The Sun Home Health Companies are required by law to perform a background and criminal investigation check. This requires a $30.00 Finger Print fee.

I hereby certify that I have given (agency ID: DHN244) The Sun Home Health Companies permission to obtain all criminal history information pertaining to me in the files of the Ohio Bureau of Criminal Identification and Investigation (BCII). By placing my Fingerprint images on the WEBCHECK Scanner, I am authorizing BCII to release criminal history information about me to the person(s)/agencies identified in this request for a period of one year from the date of this transaction.

I hereby release BCII and any and all individuals identified in this request from all liability in connection with the dissemination of such criminal history information.

I hereby acknowledge

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Orientation Confirmation

I _____ have received an orientation for my job duties from The Sun Home Health, Inc. and The Sun Home Health Care, Inc. on _____.

New Hire Signature : _____ Date : _____

Staff Signature : _____ Title : _____ Date : _____

All newly hired staff will be required to attend orientation prior to their first day of work. The Orientation will be conducted by the Supervisor and will cover the following topics :

- Badge Assignment
- Paperwork
- HIPPA Training
- Safety Procedures
- Benefits
- Grievance Policy
- Sexual Harassment Policy
- Cuitural Diversification
- Communication
- Team Work
- Job Description
- Medicare Rules, Policies and Regulations
- Medicaid Rules, Policies and Regulations
- Passort Rules, Policies and Regulations
- MRDD Rules, Policies and Regulations
- SHH Standards and Values
- OSHA Regulations

Corporate Office : 554 W Central Ave. Unit 5-6, Delaware, OH 43015
740 362 5035, **Fax No :** 866 998 1852
info@thesunhomehealth.com
www.thesunhomehealth.com

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Probation Acknowledgement

I Understand that I will not be eligible to use my personal days until I successfully complete my probationary period of ninety (90) days.

I also acknowledge that I will only be eligible for vacation time after one year of employment, in which I must have worked over at least 2,000 hours.

In order to be eligible for vacation time in any given year, I must have worked at least 600 hours in the pervious year.

Employee's Signature : _____ Date : _____

Employee's Name : _____

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