Employee Application

Name:	
Hire Date:	
DOB:	
Pay rate:	
SSN:	
Pay Type:	**Direct Deposit**
Patient(s):	

Bienestar Care Services LLC
1933 Proctor Drive Grand Prairie TX 75051

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Bienestar Care Services - Personnel File Requirements

File Name:	Title: Attendant
Address:	
Phone:	Date of Hire:
SSN:	DOB:
Pay Rate:	Term. Date:

Application	**Received**		**Received**
Reference Checked (2)		Pay Rate Form	
Application complete w/ personal reference		W-4	
Texas New Hire Form		Direct Deposit Form	
Driver's License/Identification		PPE Competency Checklist	
Social Security Card		Hand Hygiene Checklist	
Job Description		Compliance Pledge	
Conditions of Employment		I-9	
Attendant Orientation Checklist		**Health Forms**	
Verbal Orientation Checklist		TB Questionnaire	
Vesta EVV Orientation		Hepatitis B	
Compliance Pledge		**Background Check(s)**	
Statement of Employability		TX DPS Criminal History	
Confidentiality Agreement		OIG (State & Federal)	
Conflict of Interest		EMR/NAR	
HIPPA Notice		**Covid-19 Training Form**	

Exit Interview (If Needed)	Date:

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Job Description/Performance Evaluation

Title: Personal Care Attendant

Job Summary:
Primary functions: provide personal assistance and/or health-related services to patients/clients in their place of residence; provide a safe and clean environment; work cooperatively with the patient/client and family; and report observations and problems to the Supervisor.

Reporting Responsibility: Bienestar Care Services - Liz Martinez (per Agency)

Job Qualifications:

Education:	If under 18 years of age, must be either a high school graduate or enrolled in a vocational education program
Licensure:	Must have current driver's license or reliable transportation to travel to assignments
Experience:	If at least 18 years of age, have proof of competency through education and/or experience or demonstrate competency to perform tasks as assigned. If under age 18, must successfully demonstrate competency to perform tasks assigned.
Skills:	Must be able to follow written and verbal instructions and be competent to perform tasks assigned by supervisor. Demonstrates interest in the welfare of those who are elderly and/or disabled. Must successfully complete a Competency Evaluation Skills Checklist and pass a written Skills Test as required if performing G-Tube feedings.
Background Checks:	Must agree to and pass a criminal history check and an Employee Misconduct Registry check.

Environmental and Working Conditions:
Works in client's residence in various conditions; possible exposure to blood, body fluids and infectious diseases; must have the ability to work a flexible schedule and travel locally; some exposure to unpleasant weather.

Physical and Mental Effort:
Prolonged standing and walking required. Must have the ability to lift up to 50 pounds and move clients. Requires working under some stressful conditions to meet deadlines, to identify client needs, to make quick decisions and to meet client and family psychosocial needs. Requires hand-eye coordination and manual dexterity. Must have the ability to use durable medical equipment in the home.

Essential Functions:	**Evaluation:**
Promote positive, supportive, and respectful communication to the client and family and Agency personnel	
Provide an environment that promotes respect for the client's privacy and property	
Provide personal assistance or health-related tasks to client according to the Individualized Service Plan	
Appropriately report changes to ensure continuity of care	
Practice accepted infection control principles	
Provide a clean, safe, and comfortable environment	
Utilize skills necessary to perform services according to the Agency's policy	
Contribute to the management and efficient operation of the Agency and demonstrate effective time management skills	
Demonstrate commitment, professional growth and competency by attending required in-services	
Promote the Agency's philosophy and administrative policies to ensure quality of care	

Statement of Understanding:
I have read the above job description and essential functions. I understand and agree to carry out these responsibilities as assigned. I will adhere to Agency compliance with laws and regulations in a professional manner. I understand and acknowledge that nothing contained in this job description may be construed as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily.

Signature: _____ **Date:** _____

Evaluation Codes:
1 – Does not meet job requirements/expectations **2** – Occasionally meets job requirements **3** – Normally meets job requirements
4 – Meets and occasionally exceeds job requirements **5** – Regularly exceeds job requirements

Comments/Goals: _____

_____

Use back for additional comments/goals.

Signature: _____ **Date:** _____

Evaluator/Title: _____ **Date:** _____

Job Description / Performance Evaluation

Title: PHC Special Attendant

Job Summary:
Primary functions: initiate services to clients in their place of residence; prevent a break in services; provide ongoing services; provide a safe and clean environment; work cooperatively with the client and family; and report observations and problems to the Supervisor.

Reporting Responsibility: Bienestar Care Services - Liz Martinez (per Agency)

Job Qualifications:

Education:	If under 18 years of age, must be either a high school graduate or enrolled in a vocational education program
Licensure:	Must have current driver's license or reliable transportation to travel to assignments or if tasks require driving
Experience:	Meet requirements for personal care attendants and meet requirements relating to Home Health Aides: Training Course; Duties or have six continuous months of documented experience in delivering personal care tasks in family care, primary home care, personal assistance services, or client managed attendant services; or be listed as a nurse's aide on the Texas Health and Human Services (HHS) nurse aide registry.
Skills:	Must be able to follow written and verbal instructions and be competent to perform tasks assigned by Supervisor Demonstrates interest in the welfare of those who are elderly and/or disabled.
Background Checks:	Must agree to and pass a criminal history check and an Employee Misconduct Registry check.
Relationships:	CBA: Must not be the spouse or common law spouse of the client. PHC: must not be the legal parent, foster parent, or spouse of a parent of a minor client; must not be the spouse of a client except in Family Care; must not be designated as "Do Not Hire" by a Texas Health and Human Services (HHS) Case Manager.

Environmental and Working Conditions:
Works in client's residence in various conditions; possible exposure to blood, body fluids and infectious diseases; must have the ability to work a flexible schedule and travel locally; some exposure to unpleasant weather.

Physical and Mental Effort:
Prolonged standing and walking required. Must have the ability to lift up to 50 pounds and move clients. Requires working under some stressful conditions to meet deadlines, to identify client needs, to make quick decisions and to meet client and family psychosocial needs. Requires hand-eye coordination and manual dexterity. Must have the ability to use durable medical equipment in the home.

Essential Functions:	**Evaluation:**
Promote positive, supportive, and respectful communication to client and family and Agency personnel	
Provide an environment that promotes respect for the client's privacy and property	
Provide personal assistance or health-related tasks to client according to the Individualized Service Plan	
Appropriately report changes to ensure continuity of care	
Practice accepted infection control principles	
Provide a clean, safe and comfortable environment	
Use skills necessary to perform services according to the Agency's policy	
Contribute to the management and efficient operation of the Agency and demonstrate effective time management skills	
Demonstrate commitment, professional growth and competency by attending required in-services	
Promote the Agency's philosophy and administrative policies to ensure quality of care	
Meets mandatory continuing education requirements of the Agency and licensing board	
Participates in the Agency's QAPI program	
Participates in the Agency sponsored in-service trainings	

Statement of Understanding:
I have read the above job description and essential functions. I understand and agree to carry out these responsibilities as assigned. I will adhere to Agency compliance with laws and regulations in a professional manner. I understand and acknowledge that nothing contained in this job description may be construed as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily.

Signature: _____ **Date:** _____

Evaluation Codes:
1 – Does not meet job requirements/expectations **2** – Occasionally meets job requirements **3** – Normally meets job requirements
4 – Meets and occasionally exceeds job requirements **5** – Regularly exceeds job requirements

Comments/Goals: _____

_____

Use back for additional comments/goals.

Signature: _____ **Date:** _____

Evaluator/Title: _____ **Date:** _____

1933 Proctor Drive
Grand Prairie TX 75051
Office 972-332-4214
Fax 972-730-9238

Attendant Qualifications

An attendant must:

- Meet the requirements described in 26 TAC §558.404(c) (relating to Standards Specific to Agencies Licensed to Provide Personal Assistance Services);
- Not be a legal parent, foster parent, or spouse of a parent of a minor who receives services in the CAS Program;
- Not be the spouse of the individual who receives the service, except for services in the FC Program; and
- Not be designated by an HHSC caseworker on HHSC's Authorization for Community Care Services form as "Do not hire."

By signing below, I agree with the terms listed above.

_____
Printed Name

_____
Signature

_____
Date

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Personnel File Checklist

NAME:_____ **DATE:**_____

Section I

- ☐ Completed, signed Application for Employment form.
- ☐ Documentation of employment Reference Checks [at least two]
- ☐ Texas Employer New Hire Reporting Form

Section II

- ☐ Signed Job Description.
- ☐ Skills Competency Checklist. [per regs or policy] HHA____ Written exam____
- ☐ Signed Orientation Checklist
- ☐ Employee Acknowledgment
- ☐ Statement of Employability, to include results of Employee Misconduct Registry (EMR) and Nurse Aide Registry (NAR) for all unlicensed clinical staff as well as documentation that Criminal History Check was completed on-line
- ☐ Social Security Card (Copy not required in personnel file, may file with I 9 form)
- ☐ Check for OIG Exclusion List
- ☐ Compliance Pledge, upon hire and annually
- ☐ Conflict of Interest and Disclosure Statement
- ☐ W-4 tax withholding form. (Download most current version at www.irs.gov/pub/irs-pdf/fw4.pdf)
- ☐ Miscellaneous

Section III

- ☐ Documentation/copy of current license, registration/certification, or competency.
  [ST - license, MSW - Master's Degree & license]
- ☐ Verification of current license/certification [as required by State regulation]
- ☐ Current CPR, [if required]
- ☐ Current Driver's License
- ☐ Current Automobile Liability

Section IV

- ☐ Inservice Records

Personnel File Checklist

☐ Performance evaluations [at least annually or per policy] counseling forms, commendations

Health File/I-9 Checklist

Health Information File (All health files may be maintained in a sealed envelope in personnel file or in a separate file/binder in a secure location. The Joint Commission and ACHC require a separate binder)

☐ TB screening and testing as required by Agency policy

☐ Hepatitis B consent/declination

☐ Hepatitis B vaccination tracking form

Other health forms if applicable

☐ HBV/HIV exposure and exposure follow up.

☐ COVID-19 proof of vaccination and boosters or approved vaccination delay or exemption

☐ Workers' compensation forms and related documents.

☐ Medical Leave of Absence forms and related documents.

☐ Medical information related to accommodation

☐ Miscellaneous documentation of illness.

I-9 Form (Download most current version at https://www.uscis.gov/i-9 - should not be in the personnel file but kept in a separate file folder/binder in a secure location. May attach copy of social security card here but not required.

Criminal Background History Check Form should not be in the personnel file but kept in a separate file folder/binder in a secure location.

Application for Employment

We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law.

Applicant Name (last, first, middle): _____

Email Address: _____

Current Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Are you at least 18 years old? ☒ Yes ☐ No Position Applying For: Attendant

☐ Full time ☒ Part time ☐ Part time per visit ☐ Pool Shift: ☐ Day ☐ Evening ☐ Night ☐ Weekends

If you are not a US citizen, do you have the legal right to remain permanently in the US? ☐ Yes ☐ No

Salary Requirements: _____ Date Available: _____

Do you have adequate means of transportation to get to work on time each day, and when called in on short notice during normal work hours? ☐ Yes ☐ No

Educational History

Type of School	Name and Location of School	Circle Last Year Attended	Graduated	Degree
High School		9 10 11 12		
College		1 2 3 4		
College		1 2 3 4		
Other		From: To:		

List professional licenses you possess. Indicate type (i.e., license, certification, registration, etc.), number, and issuing state:

_____

_____

_____

List any memberships in professional organizations, honors, or activities which you feel would enhance your application, excluding those that would indicate race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law:

_____

_____

_____

Application for Employment

Name: _____

List languages spoken other than English:

_____

List other skills applicable to the position for which you are applying, including computer experience, typing speed, etc.:

_____

_____

Work History

Attach an additional sheet listing other work experience pertinent to the position for which you are applying if the space below is insufficient.

Company Name	Complete Address including city, state, zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business ☐ Full time ☐ Part time ☐ Per visit	Reason for Leaving	Ok to Contact Supervisor ☐ Yes ☐ No
Describe your job title, responsibilities, and accomplishments: _____ _____ _____			
Company Name	Complete Address including city, state, zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business ☐ Full time ☐ Part time ☐ Per visit	Reason for Leaving	Ok to Contact Supervisor ☐ Yes ☐ No
Describe your job title, responsibilities, and accomplishments: _____ _____ _____			

Application for Employment

Name: _____

Company Name	Complete Address including city, state, zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business ☐ Full time ☐ Part time ☐ Per visit	Reason for Leaving	Ok to Contact Supervisor ☐ Yes ☐ No
Describe your job title, responsibilities, and accomplishments: _____ _____ _____			

Personal References – Name, Phone, Relationship: **(2 Personal References Required)**

_____

_____

_____

Emergency Contact: _____

Relationship: _____ Phone: _____

Address: _____

Out-of-State Contact (if possible): _____

Relationship: _____ Phone: _____

Address: _____

Application for Employment

Please review and sign

In making application for employment:

- I certify that the information in this application is true and complete for all practical purposes. It may be verified by the Agency or any affiliate. Should a position be offered and later it is found that the information is significantly untrue, incomplete, or misrepresented, I understand and agree that the Agency or its affiliates are relieved of all commitments, financial or otherwise pertinent to employment, and that I am subject to immediate termination without recourse.
- I understand and agree that if I am offered employment by the Agency, my employment will be for no definite term and that either I, or the Agency will have the right to terminate the employment relationship at any time, with or without cause, and with or without notice. I also understand that this status can only be altered by a written contract of employment which is specific as to all material terms and is signed by me and the Administrator of the Agency.
- I understand that if I have direct patient/client contact the Agency will perform a background check, including criminal history check (if applicable), OIG LEIE check (if applicable), and any additional checks as required by accrediting body standards or state regulations. I further understand, if I am an unlicensed person, the Agency will perform a check of the Nurse Aide Registry and Employee Misconduct Registry. I understand that: 1) the purpose of the Employee Misconduct Registry is to ensure that unlicensed personnel who commit acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers are denied employment in HHS-regulated facilities and agencies; 2) the State of Texas maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by the Texas Health and Human Services (HHS) and they review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides and if there's a finding of an alleged act of abuse, neglect, or misappropriation, the nurse aide may request both an informal reconsideration and a formal hearing before the finding is placed on the registry; 3) All HHS-regulated facilities and agencies are required to check the Employee Misconduct Registry and Nurse Aide Registry before hire to determine if I am listed in either registry as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer and am, therefore, unemployable. I understand that a refusal to authorize the criminal background check may result in adverse employment action, such as rejection of the application or termination of employment.

Release: I hereby authorize any prior employers to provide such information concerning my employment with them as may be requested, and also authorize the Registrar / enrollment or admissions office of all educational institutions attended to release an official copy of my transcript and, if available, faculty appraisals. I also authorize any appropriate licensing board to release full information concerning my license status and my license history.

Applicant Signature: _____ Date: _____

FOR OFFICE USE ONLY	☐ Interview(s)	☐ References Checked	If Hired: Position: Start Date: Salary: ☐ Full time ☐ Part time ☐ Per visit

Work Reference Request

Phone #: _____

Date: _____ Check method of gathering reference data: ☒ Verbal ☐ Mail ☐ Other: _____

Reference Name: _____

Company/Facility: _____

The individual named below is applying for a position as Attendant and has given your name as a reference. Because we place a great importance on the thorough screening of all applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance, (name of representative) Liz Martinez

Applicant Release

Last Name, First, Middle: _____

Maiden/Alias (if applicable): _____

SSN: _____ Dates Employed: From _____ To _____

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need-to-know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

Applicant Signature: _____ Date: _____

---

1. Please confirm the applicant's employment dates: From _____ To _____
2. Please comment on the applicant's attributes using the following scale:

Quality of Work	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Knowledge & Skills	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Reliability & Attendance	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Cooperation	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Competence	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Supervisory Ability & Capacity	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Grooming	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable

3. Please indicate specialty areas in which the applicant has had experience: _____
4. Please indicate any special considerations necessary when giving assignments to this individual:

   _____
5. Is the applicant eligible for rehire? ☐ Yes ☐ No If no, explain: _____

Please attach any additional comments.

Signature: _____

Position / Title: _____ Date: _____

☐ Agency representative verified reference via phone call. Date _____ Signature_____

Work Reference Request

Phone #: _____

Date: _____ Check method of gathering reference data: ☒ Verbal ☐ Mail ☐ Other: _____

Reference Name: _____

Company/Facility: _____

The individual named below is applying for a position as Attendant and has given your name as a reference. Because we place a great importance on the thorough screening of all applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance, (name of representative) Liz Martinez

Applicant Release

Last Name, First, Middle: _____

Maiden/Alias (if applicable): _____

SSN: _____ Dates Employed: From _____ To _____

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need-to-know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

Applicant Signature: _____ Date: _____

---

1. Please confirm the applicant's employment dates: From _____ To _____
2. Please comment on the applicant's attributes using the following scale:

Quality of Work	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Knowledge & Skills	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Reliability & Attendance	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Cooperation	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Competence	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Supervisory Ability & Capacity	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Grooming	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable

3. Please indicate specialty areas in which the applicant has had experience: _____
4. Please indicate any special considerations necessary when giving assignments to this individual:

   _____
5. Is the applicant eligible for rehire? ☐ Yes ☐ No If no, explain: _____

Please attach any additional comments.

Signature: _____

Position / Title: _____ Date: _____

☐ Agency representative verified reference via phone call. Date _____ Signature_____

VERBAL ORIENTATION CHECK LIST

INFORMATION RECEIVED	YES	NO	N/A
Criminal history check	X		
Release of employment information	X		
Workers' compensation information	X		
Employee Handbook	X		
Abuse, Neglect and Exploitation	X		
Solicitation	X		
Rights of the Elderly	X		
HIV/AIDS	X		
Hepatitis B	X		
Tuberculosis	X		
Drug Policy	X		
Body Mechanics	X		
Emergency Preparedness Plan	X		

I have received, read and understand policies and procedures given to me. I have received, read and understand additional material provided including my job description, and modified self-study materials. I agree to have any questions clarified. I understand and agree to follow these policies, procedures and guidelines.

Print Name: _____

Signature: _____ Date: _____

I confirm that the employee named above has received all materials indicated, has had questions answered and is competent to provide services to patients/clients.
The employee has received a score of _____ on all quizzes pertaining to his/her orientation.

Agency Representative Print Name: _____

Agency Representative Signature: _____

Date: _____

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ATTENDANT ORIENTATION CHECKLIST

I. Introduction

A. Qualities of a Personal Attendant
B. Definitions
C. Goals of Care
D. Professional Conduct
E. Communication
F. Communication Skills
G. HIPAA and Confidentiality
H. Rights and Responsibilities
I. Supervision
J. Compliance Training and Education Program

II. Documentation

III. Miscellaneous

A. Paperwork deadlines
B. In-services
C. Inclement weather
D. Supplies
E. Scheduling
F. Tips for time management

IV. Safety

A. Personal
B. Driving
C. Equipment
D. Oxygen
E. Fire
F. Bathroom
G. Body Mechanics
H. Life Threatening Emergency Guidelines
I. Abuse, Neglect, and Exploitation

V. Exposure Control/Standard Precautions

A. Hand Hygiene
B. Glove Usage
C. Control of Splashing and Spraying
D. Personal Protective Equipment
E. Laundry
F. Cleaning Spills
G. Needle Stick Injury
H. Tuberculosis (TB) Precautions

VI. Nutrition Overview

VII. Psychosocial Needs

VIII. Death and Dying

_____ _____

Applicant Signature Date

_____ _____

Employer Signature Date

1933 Proctor Drive
Grand Prairie TX 75051
Office 972-332-4214
Fax 972-730-9238

Attendant Orientation Training Video

All employees are required to receive training based on the topics listed in the attendant orientation checklist. These trainings may also include HHAExchange Device or Mobile App. Please check off below which were completed:

English Training Videos

- Attendant Orientation (New Hire) Completion Date: _____
- HHAExchange Device Completion Date: _____
- HHAExchange Mobile App Completion Date: _____

Spanish Training Videos

- Attendant Orientation (New Hire) Completion Date: _____
- HHAExchange Device Completion Date: _____
- HHAExchange Mobile App Completion Date: _____

By signing below, I agree that I have received the following training listed.

_____
Printed Name

_____
Signature

_____
Date

Blank Page

STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by the Agency and agree that the Agency may conduct a State of Texas criminal history check per TX H&SC 250.006. I agree to a search of the Nurse Aide Registry and the Employee Misconduct Registry prior to employment and at least every 12 months if hired. As required, I agree to a search of the Texas Health and Human Services Commission's OIG List of Excluded Individual/Entities and the HHS - OIG Excluded Individuals/Entities Search Database prior to being hired and monthly thereafter. I understand that these checks will determine if I have a criminal conviction or have committed certain conduct that will bar me from employment with this Agency. I understand that I am unemployable if listed as unemployable in the NAR or EMR per TAC §93.3 and Tx H&SC Chapter 253.

CRIMINAL HISTORY CHECK

I have informed this Agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that my employment is pending the results of the criminal history check and that I may not have face-to-face client contact until results are returned. I will be notified of results.

CONVICTIONS BARRING EMPLOYMENT.

A. A person for whom the facility is entitled to obtain criminal history record information may not be employed in a facility if the person has been convicted of an offense listed in this subsection:
   - An offense under Chapter 19, Penal Code (criminal homicide);
   - An offense under Chapter 20, Penal Code (kidnaping, unlawful restraint, and smuggling of persons);
   - An offense under Section 21.02, Penal Code (continuous sexual abuse of a young child or children) or Section 21.11, Penal Code (indecency with a child);
   - An offense under Section 22.011, Penal Code (sexual assault);
   - An offense under Section 22.02, Penal Code (aggravated assault);
   - An offense under Section 22.04, Penal Code (injury to a child, elderly individual, or disabled individual);
   - An offense under Section 22.041, Penal Code (abandoning or endangering a child);
   - An offense under Section 22.08, Penal Code (aiding suicide);
   - An offense under Section 25.031, Penal Code (agreement to abduct from custody);
   - An offense under Section 25.08, Penal Code (sale or purchase of a child);
   - An offense under Section 28.02, Penal Code (arson);
   - An offense under Section 29.02, Penal Code (robbery);
   - An offense under Section 29.03, Penal Code (aggravated robbery);
   - An offense under Section 21.08, Penal Code (indecent exposure);
   - An offense under Section 21.12, Penal Code (improper relationship between educator and student);
   - An offense under Section 21.15, Penal Code (improper photography or visual recording);
   - An offense under Section 22.05, Penal Code (deadly conduct);
   - An offense under Section 22.021, Penal Code (aggravated sexual assault);
   - An offense under Section 22.07, Penal Code (terroristic threat);
   - An offense under Section 32.53 Penal Code (exploitation of a child, elderly individual, or disabled individual);
   - An offense under Section 33.021, Penal Code (online solicitation of a minor);
   - An offense under Section 34.02, Penal Code (money laundering);
   - An offense under Section 35A.02, Penal Code (Medicaid fraud);
   - An offense under Section 36.06, Penal Code (obstruction or retaliation);
   - An offense under Section 42.09, Penal Code (cruelty to livestock animals), or under Section 42.092, Penal Code (cruelty to non-livestock animals);
   - A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection; or
   - An offense the Agency determines to be contraindicated to employment with the consumers the Agency serves.

STATEMENT OF EMPLOYABILITY

B. A person may not be employed in a position the duties of which involve direct contact with a client in a facility or may not be employed by an individual employer before the fifth anniversary of the date the person is convicted of:
- An offense under Section 22.01, Penal Code (assault), that is punishable as a Class A misdemeanor or as a felony);
- An offense under Section 30.02, Penal Code (burglary);
- An offense under Chapter 31, Penal Code (theft) that is punishable as a felony);
- An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or a felony; or
- An offense under Section 32.46, Penal Code (securing execution of a document by deception) that is punishable as a Class A misdemeanor or a felony.
- An offense under Section 37.12, Penal Code (false identification as a peace officer; misrepresentation of property); or
- An offense under Section 42.01 (a) (7), (8), or (9), Penal Code (disorderly conduct).

C. In addition to the prohibitions on employment prescribed by Subsections (A) and (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:
- Of an offense under Section 30.02, Penal Code (burglary); or
- Under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.

D. For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with, Article 42A.111 Code of Criminal Procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment. 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

For Agency Use Only: Criminal History, Employee Misconduct Registry (EMR), Nurse Aide Registry (NAR), and OIG Exclusion Lists checks completed:

☒ Criminal History Check completed on-line ❑ Other Convictions identified on Criminal History. (Document the reason for hiring in Comments below.)

❑ NAR ☒ EMR checked online at https://emr.dads.state.tx.us/DadsEMRWeb/https://emr.dads.state.tx.us/DadsEMRWeb/

☒ OIG Exclusion Lists checked at https://oig.hhsc.state.tx.us/Exclusions/Search.aspx and http://www.oig.hhs.gov/fraud/exclusions.asp

❑ Applicant employable ❑ Applicant not employable ❑ Comments:

_____ _____

Verified By Date

Employee Acknowledgement

Confidentiality: The Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the clients according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Due to the nature of our work, each employee will gain, directly or indirectly, sensitive and confidential information regarding clients and staff members. The healthcare professional safeguards the client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal client information, etc. This information should be shared only with those persons whom, due to their position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If an employee is in doubt as to whether or not certain information may be shared, the employee should consult with his or her supervisor.

Drug Testing Policy: The Agency maintains a Drug-Free Workplace policy with regard to the possession, use, distribution, and sale of drugs or alcohol. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession, or use of a controlled substance or any alcoholic beverages while in the workplace or on company paid time. Violation of this policy can result in disciplinary action up to and including termination of employment. I acknowledge I have received receipt of a copy of the Agency's policy on drug testing.

Harassment Policy: The Agency is committed to providing a work environment that is free from all forms of discrimination and unlawful harassment including sexual harassment. This policy applies to all employees including management personnel. Sexual harassment is any unwelcome sexual advances, either explicit or implicit, as a term or condition of employment. Improper behavior may be verbal, visual, or physical in nature and/or the creation of a hostile environment. Management will investigate complaints of sexual harassment promptly, impartially, and without fear of retaliation to the employee. An employee should report the alleged incident immediately and confidentially to the appropriate manager or to human resources.

Non-Solicitation/Illegal Remuneration: The Agency does not reimburse or provide incentives to physicians, durable equipment providers, families, or other referral entities for patient/client referrals for home health services. Employees may not solicit patients/clients for the Agency. Employees found in violation of this non-solicitation policy will be subject to discipline up to and including termination of employment.

Non-Discrimination: The Agency does not discriminate against employees based on race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law. The employee may file a report of a grievance or complaint regarding discrimination with the Office of Civil Rights within 180 days of when the employee knew of the situation.

Non-Discrimination: The Agency does not discriminate in patient/client provision of services with respect to race, color, national origin, age, sex, disability, marital status, religion, or source of payment according to Title VI of the Civil Rights Act.

Abuse, Neglect, and Exploitation: Agency employees will report suspected abuse, neglect, and/or exploitation to Texas Department of Family and Protective Service, Texas Health and Human Services, and Agency management. Agency employees suspected of abuse, neglect, or exploitation will be suspended immediately, an investigation will be conducted, and if the investigation validates the claim, the employee will be terminated.

Worker's Compensation: The Agency is a non-subscriber to worker's compensation insurance. An employee who incurs an injury on the job that requires emergency medical treatment or is life threatening should proceed to the nearest emergency room. Emergency medical treatment (non-life threatening) or non-emergency treatment should be referred to the Agency's designated clinic. Notify the Agency of an injury within 24 hours to complete paperwork. Medical expenses for injuries are covered with the exception of the following: employee's willful intent to hurt self or others, intoxication or drug use, horseplay, acts of God, and/or acts of a third-party.

Progressive Discipline Policy: The Agency utilizes a progressive discipline process in cases of misconduct or unacceptable performance. This includes a verbal warning, written warning, and final warning. Disciplinary action may begin at an advanced stage of the process or may result in immediate termination based upon the nature and severity of the offense, the employee's past record, and other circumstances.

Agency Policies: I acknowledge that I have read, understand, and will comply with all applicable Agency policies and guidelines.

Employee Signature: _____ Date: _____

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TB Fact Sheet/Risk and Symptom Screening

Tuberculosis (TB)

Tuberculosis (TB), caused by the *Mycobacterium tuberculosis* complex, is transmitted by the inhalation of infectious aerosol droplets created when a person with active pulmonary TB coughs, sneezes, or shouts. A person may have no symptoms (asymptomatic), but still have latent TB infection that may develop into active TB at some point. After exposure, TB skin tests may become positive within two to twelve weeks.

Risk Factors

Check any of the following risk factors that apply:

Groups with a higher risk of exposure and infection*

- ☐ Low income / medically underserved populations
- ☐ Residents or employees of congregate living facilities (e.g., homeless shelters, long-term care facilities, correctional facilities)
- ☐ Infants, children, or adolescents who are exposed to adults in high-risk categories
- ☐ Foreign-born persons, recently arrived (within five years) from areas with a high incidence of TB, such as Asia, Africa, eastern Europe, and Latin America and Russia, or those who frequently travel to areas with a high incidence of TB
- ☐ Close contact with individuals with pulmonary TB, persons who inject illicit drugs, or other locally identified high risk substance users (e.g., cocaine users)

*Flexibility is needed in defining local high priority groups for screening

Groups with a greater risk to profess from latent TB infection to active disease

- ☐ Individuals with HIV/AIDS, silicosis, diabetes, chronic renal failure, more than 10% below normal body weight, hematologic disorders (e.g., leukemias and lymphomas), and other specific malignancies (e.g., carcinoma of the head or neck)
- ☐ Those receiving certain medical treatments that may increase risks, such as prolonged corticosteroid use, other immunosuppressive treatments, bone marrow or organ transplant, intestinal bypass, or gastrectomy
- ☐ Persons with a history of untreated or inadequately treated TB disease

Signs and Symptoms of TB Disease in the Lungs*

Check if you have any of the following symptoms:

- ☐ Sweating at night
- ☐ Unexplained weight loss
- ☐ Loss of appetite
- ☐ A bad cough lasting more than three weeks
- ☐ Coughing up blood or sputum (phlegm from deep inside the lungs)
- ☐ Chills
- ☐ Fever
- ☐ Weakness or fatigue
- ☐ Chest pain

*Symptoms of TB disease in other parts of the body depend on the area affected

- ☐ I am not experiencing any of the above symptoms
- ☐ None of the above risk factors apply to me

I understand if I am experiencing any of the above symptoms, follow-up will be required. Additionally, I understand if I have any of the above symptoms at any time in the future, I am to report to management immediately and follow-up will be required at that time.

Signature: _____ Date: _____

Hepatitis B Vaccination

Due to occupational exposure to blood or other potentially infectious materials, employees may be at risk for acquiring hepatitis B viral (HBV) infection. The vaccination series is available to employees at no cost. Please indicate below acceptance or declination to receive the vaccine.

Hepatitis B is a bloodborne virus which can cause a range of symptoms from mild to serious, and possibly result in fatal liver damage to those who become infected. The virus can be transmitted through contact with infectious fluids of a person who has the hepatitis B virus. The Agency teaches the concepts of standard precautions concerning safe client care and the use of PPE to avoid unnecessary exposure.

The synthetic hepatitis B vaccine is derived from yeast cells. It is not composed of human blood or plasma. It is given as a series of three injections into the arm muscle at prescribed intervals over a six-month period. It has proven to be 80-90% effective in protecting against contracting the disease. There may be hypersensitivity to the vaccine, and there may be soreness and swelling of the injection arm. Other side effects may occur at an incidence of under 3% of injections.

The vaccine will not be given to persons with known sensitivity to aluminum hydroxide, thimerosal, yeast, or the hepatitis antigen, and will only be given with a personal physician's recommendation in the cases of pregnancy or the presence of other infections of an immunosuppressive state. The vaccine does not grant 100% assurance of immunity.

Acceptance: I have read the above information describing the risks and benefits of receiving the vaccination. I understand that the decision to receive the vaccination series is mine and I wish to receive the hepatitis B vaccine.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

Declination: ☐ I have been given the opportunity to be vaccinated for hepatitis B at no charge. I decline the vaccination series. I understand that by declining this vaccine, I continue to be at risk for acquiring hepatitis B. If I continue to have occupational exposure to blood or other potentially infectious material and decide I want to be vaccinated with hepatitis B vaccine, I may receive the vaccination series at no charge to me.

☐ I have already received the hepatitis B vaccine series at an earlier date. Select one:

☐ I will be providing a copy of the record to the Agency.

☐ I will NOT be providing a copy of the record to the Agency.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

Confidentiality of Client Information

- I plan to utilize electronic documentation of client care.
- I will ensure confidentiality and security of client information by password protecting the device or program utilized.
- I agree to change the password at least quarterly or following a breach of security.
- I will not provide my password to anyone.
- I will use an electronic signature, if acceptable to payor source. Authentication will be available if requested by the Agency.
- I have been informed of the Agency's Medical Record Information Confidentiality Policy and Safeguarding Medical Record Content Policy, and I agree to abide by these policies.

_____

Printed Name

_____ _____

Signature Date

CONFIDENTIALITY/CONFLICT OF INTEREST DISCLOSURE STATEMENT

CONFIDENTIALITY/NON-DISCLOSURE OF COMPANY OR CLIENT INFORMATION:

Access to any confidential or proprietary information will be limited to the minimum required for the performance of duties as relates to each individual=s job. Any confidential information created, received, maintained, used, disclosed, accessed, or transmitted in the performance of job duties will be maintained and protected from unauthorized disclosure.

The Health Information Portability and Accountability Act (HIPAA) ensures the client=s right to privacy of Protected Health Information to be maintained at all times. Any information related to the care of clients through this Agency will be held as confidential. All information, written or verbal, will be disclosed only to appropriate health care personnel, appropriate staff, those with a Aneed to know basis@, or to individuals the client requests.

CONFLICT OF INTEREST DISCLOSURE STATEMENT:

I acknowledge I have read the policy and procedure regarding conflict of interest and the procedure for disclosure. I understand that if I have an outside relationship that is personal, professional, or otherwise, with a client, vendor, or potential business associate, I must disclose the nature of that relationship to my supervisor, or Administrator as soon as the relationship is established. I also understand that I forfeit any voting privileges, decision making capacity, and input from any activities associated with said relationship.

☒ I have no conflict of interest to report.

☐ I, as a staff member or a Governing Body member, am providing the following disclosure of potential conflict of interest:

_____

_____

_____

Printed Name

_____ _____

Signature Date

Reported conflict of interest reviewed by the Governing Body with the following decision(s) made:

_____

_____

_____ _____

Governing Body Member Signature Date

Personal Protective Equipment (PPE) Competency Checklist

Last Name, First:	Job Title: Attendant
Evaluator:	Date:
Type of Validation: ☒ Orientation ☐ Annual/Periodic Review ☐ Other:	

Donning and Doffing of Personal Protective Equipment (PPE)			
Skills	**Competency**		
	YES	**NO**	**Comments**
Identifies the proper PPE to gather and verbalizes all appropriate PPE is available at point of use.	X		
Verbalizes proper steps in examining PPE for defects.	X		
(PPE should ideally be put on outside of the home prior to entry. If unable to put on all PPE outside of the home, it is preferred that face protection (i.e., respirator and eye protection) be put on before entering home.) Demonstrates the ability to follow the proper sequence for donning PPE in the following order:	X		
1. Hand hygiene using hand sanitizer for 20 seconds, cleansing all parts of the hands, fingers, and nail beds;	X		
2. Dons gown: fully covering torso from neck to knees and arms to ends of wrists; wrap around back; tie/fasten in back of neck and waist;	X		
3. Dons N95 respirator while ensuring air-tight fit;	X		
4. Performs seal check;	X		
5. Dons face shield: placing over face and eyes; adjust to fit as needed; and	X		
6. Dons gloves to cover wrist of gown.	X		
Enters the patient home.	X		
(PPE should ideally be removed outside of the home and discarded after visit. If unable to remove all PPE outside of the home, it is preferred that face protection (i.e., respirator and eye protection) be removed only after exiting the home.) Demonstrates the ability to follow the proper sequence for doffing PPE in the following order	X		
1. Exits patient home.	X		
2. Doffs gloves: Grasp outside of glove with opposite gloved hand, peel off using glove in glove technique. Discards in appropriate waste container.	X		
3. Doffs gown: Untie lower ties first and upper last without contamination using arm cross method. Pull away from neck and shoulders, touching inside of gown. Folds or rolls into bundle and discards in appropriate waste container.	X		

Personal Protective Equipment (PPE) Competency Checklist

4.	Doffs mask/face shield: Grasp bottom, untie lower ties first and upper last, pulling up and away from head. Avoid touching front of mask/respirator. Discards in appropriate waste container or stores mask for reuse per policy.	X		
5.	Discards all PPE by placing in external trash can before departing location. PPE should not be taken from the home in staff vehicle.	X		
6.	Performs hand hygiene using hand sanitizer.	X		

Applicant Signature:	**Date:**
Evaluator Signature:	**Date:**

Hand Hygiene Competency Checklist

Name: _____ Attendant _____

Last First Job Title

Evaluator Name: _____ Date: _____

Type of Validation: X Orientation Annual Other:

Skills	Competency		
	Yes	No	Comments
Hand Hygiene with Soap and Water:	X		
1. Identifies and gathers the appropriate supplies;	X		
2. Wets hands with water using temperature that is comfortable;	X		
3. Applies an amount of product recommended by the manufacturer to hands, and rubs hands together vigorously for at least 20 seconds, covering all surfaces of hands, fingers and nailbeds;	X		
4. Rinses thoroughly with water;	X		
5. With hands held upright, dries thoroughly with a clean paper towel; and	X		
6. Turns the faucet off using a dry paper towel to touch the handle, protecting clean hands from the contaminated handle.	X		
Verbalizes and/or Demonstrates When Hand Hygiene	X		
1. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids;	X		
2. Before eating and after using the restroom; and	X		
3. After known or suspected exposure to clostridium difficile, infectious diarrhea during norovirus outbreaks, or if exposure to *Bacillus anthracis* is suspected or proven.	X		

Hand Hygiene Competency Checklist

Hand Hygiene with Alcohol-Based (60-95%) Hand Rub:	X		
1. Applies product to palm of one hand (Follows the manufacturer's recommendations regarding the volume of product to use).	X		
2. Rubs hands together covering all surfaces of hands and fingers until hands are dry, this should take around 20 seconds.	X		
Verbalizes and/or Demonstrates When Hand Hygiene Indicated:	X		
1. Prior to initial entry into the supply bag;	X		
2. Before having direct contact with the patient;	X		
3. After direct contact with the patient;	X		
4. After contact with body fluids or excretions, mucus membranes, wound dressings and used supplies (PPE);	X		
5. After known or suspected exposure to infections or infectious diseases;	X		
6. Before handling or preparing medication;	X		
7. Before moving from a contaminated-body site to a clean-body site on the same patient during patient care;	X		
8. After having contact with inanimate objects (including medical equipment) in the patient's environment;	X		
9. Before contact with or the preparation of food items and beverages; and	X		
10. After removing gloves.	X		

Signature of App: _____ Date: _____

Signature of Evaluator: _____ Date: _____

1933 Proctor Drive
Grand Prairie TX 75051
Office 972-332-4214
Fax 972-730-9238

Employee Job Acceptance

Dear Employee,

This form is is to confirm that you have been accepted for your employment as _____ (enter job title) as of _____ (enter date). This confirmation of employment was given due to the fact that the applicant completed the following:

- ☐ Job Application
- ☐ Criminal History Seacrch
- ☐ EMR
- ☐ OIG
- ☐ Copy of Identification (License, Resident Card, or etc)

We look forward to working with you. For any questions or concerns of your employment you must contact the office and speak with the hiring manager at 972-332-4214.

_____ _____

Employee Signature **Date**

_____ _____

Supervisor Signature **Date**

1933 Proctor Drive
Grand Prairie TX 75051
Office 972-332-4214
Fax 972-730-9238

Payment Rates for Primary Home Care, Community Attendant Services, Family Care and Personal Attendant Services (IL No. 2023-33)

The Texas Health and Human Services Commission (HHSC) approved the payment rates for Community Attendant Services (CAS) / Family Care (FC) / Primary Home Care (PHC); Community First Choice (CFC); Community Living Assistance & Support Services (CLASS) Waiver; Day Activity and Health Services (DAHS); DeafBlind Multiple Disabilities (DBMD) Waiver; Home and Community-Based Services (HCS) Waiver; Home and Community-Based Services Adult Mental Health (HCBSAMH); Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID); Residential Care (RC); STAR Kids / STAR Health – Medically Dependent Children Program (MDCP) Waiver and Non-MDCP; STAR+PLUS Home and Community-Based Services (HCBS) and Non-HCBS; Texas Home Living Waiver (TxHmL) Program to be effective September 1, 2023.

Attendant services are non-technical, medically related, or personal care services provided to people at home or in community living settings. Long-term Services and Support (LTSS) attendant services include assisted living, employment services, habilitation, chores services, non-medical transportation, in-home respite, supervised living, and residential support services. The 2024-25 General Appropriations Act, House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 30(a)) increases the base wage for attendants from $8.11 to **$10.60 per hour**.

As an employee, I have been notified of the minimum attendant base wage. **I agree to my pay wage being increased to $10.60 per hour starting on 9/1/23. This pay increase will reflect on 9/25/23.** I have also signed an employee pay rate form that confirms my rate as an attendant for Bienestar Care Services. If I have any questions or concerns regarding the base wage, I must contact the agency at 972-332.4214.

By signing below, I agree with the terms listed above.

_____
Employee Printed Name

_____
Employee Signature & Date

_____
Agency Representative Signature & Date

Bienestar Care Services
Employee Pay Rate Form

Applicant Name: _____ **Date:** _____

I have been provided the following job description form for:

- ❑ Administrator
- ❑ Alternate Administrator
- ❑ Administrative Assistant
- ❑ Supervisor (Field & Office)
- ❑ Community Coordinator
- ❑ Clerical
- ❑ Attendant

My pay rate:

- ❑ **Annual Salary: _____**
- ❑ **Monthly Salary: _____**
- ❑ **Per visit: _____**
- ❑ **Per hour: _____**

I have accepted both job description and pay rate with this agency. BY signing below I agree with the terms stated above.

_____ _____

Applicant Sign **Date**

_____ _____

Agency Representative Sign **Date**

COMPLIANCE PLEDGE

(Completed On Hire and Annually)

The undersigned is a current Governing Body member, owner, officer, director, or person who performs billing or coding functions on behalf of the Agency or an employee of the Agency. In that capacity, the undersigned hereby affirms that:

I have received the Agency Standards of Conduct, have had an opportunity to have questions regarding the Standards of Conduct answered, and agree to conduct myself in accordance with same in all dealings with or on behalf of the Agency;

I have completed the Compliance Training and Education Program as required by the Agency Compliance Program;

I am not aware of any actual or potential unreported activity by any person or entity acting for or in conjunction with the Agency which is known or believed by me to be in violation of any applicable federal or state law, rule, or regulation;

I understand the importance of compliance with applicable laws, rules, and regulations to the Agency and to the government and third-party payers;

I understand that all Agency representatives are expected to report any suspected violations of these laws, regulations, or rules to their supervisor or the Compliance Officer. I understand that I must also report any suspected violations of the policies or the standards and procedures of the program, and that I may anonymously report any suspected violations through the Compliance Dropbox or the Hotline # 972-332-4214 ;

I understand that conduct in accordance with the Agency Compliance Program will be a condition of my continued relationship with the Agency. I understand that failure to comply with the program may subject me to sanctions or discipline, including but not limited to termination of employment, and/or privileges; and

I am not currently and have not been subject to any criminal charge or conviction involving any government business nor any conviction, exclusion action, disciplinary action, debarment or proposed debarment, or loss or limitation of licensure, privilege, or employment as a result of any alleged violation of applicable state or federal law, rule or regulation.

Signed this _____ day of _____, 20_____.

_____

Signature

_____

Printed Name

Attendant

_____

Title or Job Description

ATTENDANT ORIENTATION

Individual's Name	Individual's HHS' No.	Attendant(s) Name(s)
Frequency of Supervisory Visits	Date of Orientation	A
Orientation conducted in person with the individual ☐	By phone or in the office without the participation of the individual ☐	B

Describe how the individual's functional limitations affect the performance of tasks:

_____

Tasks: Mark tasks to be performed and frequency. *Personal Care tasks (PHC/CAS require at least on personal care task.)

	FREQ.		FREQ.		FREQ.
☐ **Bathing***		☐ **Routine Hair/Skin Care**		☐ **Laundry**	
☐ **Dressing***		☐ **Toileting***		☐ **Meal Preparation***	
☐ **Exercise***		☐ **Transfer***		☐ **Escort**	
☐ **Feeding/ Eating***		☐ **Walking***		☐ **Shopping**	
☐ **Grooming/ Shaving, Oral Care***		☐ **Cleaning**		☐ **Assist w/Self-Admin Meds***	

Attendant Schedule

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total
Attendant A								
Attendant B								
TOTALS								

TOTAL NUMBER OF HOURS THE INDIVIDUAL IS AUTHORIZED TO RECEIVE: _____

☐ Attendant instructed about tasks to be provided, work schedule, safety, and emergency procedures, including Standard Precautions.

☐ **Attendant(s) is/are over 18 and is/are not related to the client other than as allowed by the PHC Program.**

Report the following situations or occurrences immediately:

☐ Changes in the individual's needs of the individual

☐ Incidents that affect the individual's condition

☐ Hospitalization of the individual

☐ Suspicion or allegation of abuse, neglect, or exploitation

☐ Safety in individual's home (Specific to setting)

☐ Safety when cooking (if task)

ATTENDANT ORIENTATION

☐ Individual's absence or relocation from home
☐ The PHC individual did not get the monthly Medicaid letter
☐ You are unable to work your scheduled hours
☐ Standard precautions - stressed hand washing
☐ Body mechanics (How to lift and transfer)
☐ Other: _____

INDIVIDUAL'S CERTIFICATION: the PHC Program only provides the tasks allowable in the program as described in §47.41 of this chapter (relating to Allowable Tasks) and agreed to on the service delivery plan; and the provider is not responsible for meeting the applicant's needs other than tasks allowed under the PHC Program. Additionally, I hereby acknowledge that if my priority status with HHS is determined to be "non-priority", I may have a break in services of up to 14 days.

_____ _____

Signature - Individual or Responsible Person | Attendant's Signature

_____ _____

Supervisor's Signature | Attendant's Signature

Bienestar Care Services
HHAExchange
Orientation

Applicant Name: _____ **Date:** _____

Below are the topics listed in regards to Electronic Visit Verification:

- Introduction of HHAExchange
- Clock in/out Process
- Different devices that are available for use
    - Landline
    - Device
    - Mobile App
- Employee responsibilities
- Discipline (If an employee fails to properly use.)
- Training form
- Schedule
- Surprise checks
- Termination
- Troubleshooting

By signing this form, I understand the following that was stated above. I must report any issues to the office immediately. If I fail to report it will result in a short pay. If I fail or become not compliant with any of the policies then it will lead to me being immediately terminated and a report will be filed.

_____ _____

Applicant Sign **Date**

_____ _____

Agency Representative Sign **Date**

Bienestar Care Services
HHAExchange Reminders

Applicant Name: _____ **Date:** _____

Below are rules/reminders I must follow while using the EVV System:

- I am not allowed to remove any HHAexchange Device from the member's/ client's home. If the client/member moves out from their home I must notify the office in order for the device to be moved by an agency rep.
- I must report when the client/member is out of town. I am not allowed to clock in/out when the client is not home. I cannot provide service outside of the authorized counties. I am not allowed to clock in/out outside the state of Texas.
- I must report to the agency if I am unable to work or cannot make it to a work shift. I cannot send a back up worker unless it has been approved by the agency beforehand.
- I cannot take the device home with me. The Device is not allowed to be carried as a key chain or moved to different locations.
- If I use the app, I understand that if I fail to report any issues it can result in my check being short. This also applies to any days that are not clock in/out properly.
- If I lose or damage the HHAexchange device, I am responsible for the payment of a replaced device. I will be charged a $20 fee for a replacement from my check.
- I cannot change my schedule and not notify the agency. If I fail to notify the office of any changes, it can result in my check being affected.

By signing this form, I understand the following that was stated above. I must report any issues to the office immediately. If I fail to report it will result in a short pay. If I fail or become not compliant with any of the policies then it will lead to me being immediately terminated and a report will be filed.

_____ _____

Applicant Sign **Date**

_____ _____

Agency Representative Sign **Date**

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		Supervisor

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		Bienestar Care Services LLC

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
1933 Proctor Drive	Grand Prairie	TX	75051

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

Texas Employer New Hire Reporting Form

Submit within 20 calendar days of new employee's first day of work to:

ENHR Operations Center, P.O. Box 149224
Austin, TX 78714-9224
Phone: 1-800-850-6442 FAX: 1-800-732-5015
Online: www.employer.texasattorneygeneral.gov

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C		1	2	3

Employer Information

1. Federal Employer ID Number (FEIN):
Please use the same FEIN that appears on quarterly wage reports.

8 3 1 2 7 5 0 1 3

2. State Employer ID Number (Optional):

3. Employer Name:

BIENESTAR CARE SERVICES

4. Employer Address (Please indicate the address where the Income Withholding Orders should be sent):

1933 PROCTOR DRIVE

5. Employer City (if US):

GRAND PRAIR

6. State (if US):

TX

7. ZIP Code (if US):

75051 –

8. Province/Region (if foreign):

9. Country (if foreign):

10. Postal Code (if foreign):

11. Employer Telephone (Optional):

12. Employer FAX (Optional):

13. New Hire Contact Person (Optional):

Employee Information

14. Social Security Number (SSN):

15. Date of Hire (MM/DD/YYYY):

16. Employee First Name:

17. Employee Middle Name:

18. Employee Last Name:

19. Employee Home Address:

20. Employee City (if US):

21. State (if US):

22. ZIP Code (if US):

–

23. Province/Region (if foreign):

24. Country (if foreign):

25. Postal Code (if foreign):

26. State Where Employee Was Hired (Optional):

27. Employee DOB (MM/DD/YYYY) (Optional):

28. Employee's Salary (Dollars and Cents) (Optional):

29. Salary Frequency (Check One ONLY) (Optional):

☐ Hourly ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

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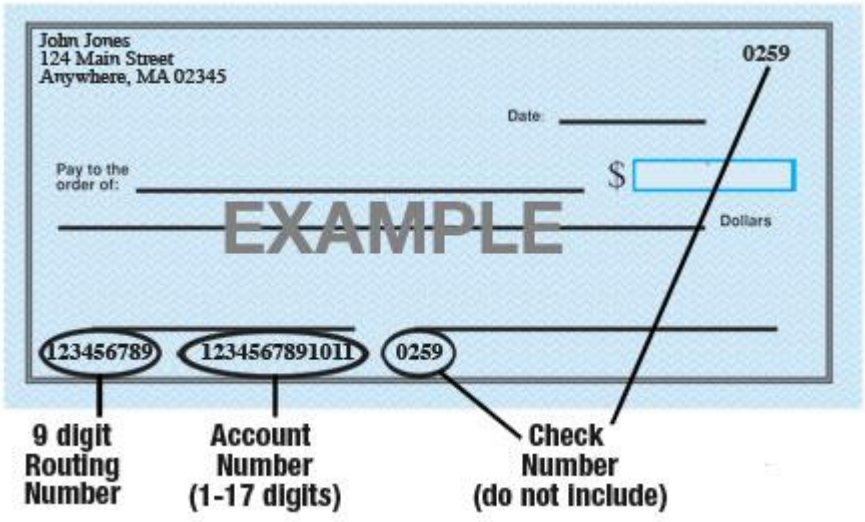
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ $ _____ ☐ _____% or ☐ Entire Paycheck

Type of Account: Checking Savings (Circle One)

Please attach a voided check for each bank account to which funds should be deposited.

Bienestar Care Services LLC is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) _____ **Date** _____

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Bienestar Care Services 1933 Proctor Drive Grand Prairie TX 75051		83-1275013

1933 Proctor Drive
Grand Prairie TX 75051
Office 972-332-4214
Fax 972-730-9238

Employee TCR Registration

As of March 31, 2023, our agency is now required to have a consent form for each employee to be able to send text messages via our agency phone line. Our agency sends messages to employees for updates, changes, schedules, alerts, or personal information.

Attestation: By filling out the form below, I allow Bienestar Care Services to text me as an employee. These messages contain updates, changes, schedules, alerts, or personal information. If I wish to opt out of receiving any text messages from the agency I will simply reply with the message "OPT-OUT" and the agency will no longer send me any future message.

_____

Employee Signature

_____

Employee Printed Name

_____

Phone Number

_____

Date

Blank Page

Bienestar Care Services
Employee Covid-19 Orientation Checklist

Employee Printed Name: _____

All employees under Bienestar Care Services are required to complete a training form Covid-19. Screenings were only required for July 2022 - July 2022.

- ➔ Daily Employee/Client Screening (Via Phone & Office Visits)
- ➔ Face Mask Policy
- ➔ Mask Seal Test
- ➔ Covid-19 Symptoms (For All Variants)
- ➔ Sick & Infection Policies
- ➔ Covid-19 Testing
- ➔ Monitoring & Reporting Any Active Infections
- ➔ Exposure & Log
- ➔ What Happens If An Employee Test Positive
- ➔ What Happens if A Client/Family Member Test Positive
- ➔ PPE Guideline
- ➔ PPE Release Form
- ➔ Prevention Guidelines
- ➔ Stay At Home Orders
- ➔ Alerts & Reporting
- ➔ Outbreaks
- ➔ Texas Covid-19 Information
- ➔ Local & State Depts For Reporting

By signing the form below, I understand all Covid-19 Policies and will comply with the Agency Policies & Procedure. Failure to comply can result in my termination. These policies became effective on July 22, 2020.

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

Pandemic Inservice Sign In Sheet

Agency: Bienestar Care Services

Date: _____ **Time In:** _____ **Time Out:** _____

Name of In-Service: Orientation Employee In-Service

Presented By: Liz Martinez

Signature of Presenter: _____ **Date**:_____

- [x] Emergency Preparedness and Response Plan - Pandemic Specific Information
- [x] Updated and/or new policies related to pandemic
- [x] Hand Hygiene Recommendations
- [x] Personal Protective Equipment (PPE) Recommendations
- [x] Cleaning and Management of Supplies and Equipment Recommendations
- [x] Return to Work Criteria for Healthcare Workers
- [x] Work Schedule/Employee Time Off/Overtime/Family Medical Leave Act (FMLA)

In Attendance:

	Name	Title
1.		Attendant
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		

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Employee Attestation of COVID-19 Vaccination Status

Employee Name: _____ Title: Attendant

The Agency is committed to providing all our employees with the safest possible workplace. As part of the COVID-19 Plan, we need to record who has or has not received a vaccine for COVID-19.

Please check the box that describes your COVID-19 Vaccination status:

- ☐ I have not received any COVID-19 vaccine.
  - ☐ I am scheduled to receive the first dose on _____(date).
  - ☐ I do not plan to receive the vaccine. Reason: _____

    _____
- ☐ I have received one COVID-19 Vaccine, and a second dose is scheduled on _____(date) as per manufacturer's requirement.
  Type of vaccine _____; administered by (clinic, doctor) _____
- ☐ I have received all COVID-19 Vaccine injections as required per manufacturer with the last dose on _____(date). I understand I am considered fully vaccinated two weeks after the last dose.
  Type of vaccine _____; administered by (clinic, doctor) _____
- ☐ I have received a booster dose for COVID-19 as recommended on _____(date).
  Type of vaccine _____; administered by (clinic, doctor) _____
- ☐ I have lost or am otherwise unable to produce required proof of COVID-19 vaccination.

By my signature below, I certify that this statement about my vaccination status is true and accurate. I understand that knowingly providing false information regarding my vaccination status on this form may subject me to criminal penalties.

Employee Signature: _____ Date _____

Witness Signature: _____ Date _____

Blank Page

1933 Proctor Drive
Grand Prairie TX 75051
Office 972-332-4214
Fax 972-730-9238

Employee Health Insurance Declination

I, _____, confirm that I decline any health insurance that will be provided By Bienestar Care Services. The following reason is stated below:

- I decline in having Health Insurance by Bienestar Care Services
- I currently have an existing Health Insurance either private or by the Marketplace
- I currently have an existing Health Insurance due to another job
- I currently have an existing Health Insurance from my spouse
- I do not meet the requirements to have Health Insurance by Bienestar Care Services

_____
Employee Signature & Date

_____
Agency Representative Signature & Date

Blank Page

1933 Proctor Drive
Grand Prairie TX 75051
Office 972-332-4214
Fax 972-730-9238

Employee Handbook & Attendant Orientation Manual

I, _____, confirm that I received the agency's employee handbook along with the Attendant Orientation Manual. The signature below confirms the receipt and Acceptance. I also confirm that I have read and understood everything listed in the handbook And orientation manual. I accept the responsibility of following all it's policy and procedures.

_____
Employee Signature & Date

_____
Agency Representative Signature & Date

Blank Page

In-Service/Exercise Sign In List

Agency: _____

Date: _____Time In: _____Time Out: _____

Name of In-Service: _____

Presented By: _____

Presenter Signature: _____Date: _____

❑ Emergency Preparedness and Response Plan

Subject Summary: The Agency's Emergency Preparedness and Response Plan, policies, and procedures reviewed. Topics included definitions, risk assessment analysis, continuity of operations, patient/client triage, communication / disaster calling tree, securing office building, IT systems, utility disruptions, off-site location, employee responsibilities, and media / information management through all phases of plan.

❑ Planned Drill (The planned drill may be limited to the Agency's procedures for communicating with staff)

❑ Actual Emergency Event

❑ Annual Fire Drill

Complete the Agency Emergency Preparedness Plan Evaluation or the Evaluation of Emergency Preparedness Exercise or Event Sheet and any additional information and attach to this Sign In Sheet.

In Attendance:

Name	**Title**
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	
6. _____	
7. _____	
8. _____	
9. _____	
10. _____	

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1933 Proctor Drive Grand Prairie TX 75052
Office 972.332.4214 **Fax** 469.895.9867

Attendant Exposure Control - HP B & Bloodborne Pathogens

The agency will provide training and education to the topics listed below that are related to Hepatitis B and Bloodborne pathogens. This training will be conducted upon hire and annually thereafter.

All information will reference the following;

- Communicable Disease Prevention and Control Act, Health and Safety Code, Chapter 81 and State List of Notifiable Conditions, updated annually (found under the Texas Department of State Health Services website, Infectious Diseases).
- The Occupational Safety and Health Administration (OSHA), 29 CFR Part 1910.1030 and Appendix A relating to Bloodborne Pathogens
- The Health and Safety Code, Chapter 85, Subchapter I, concerning the prevention of the transmission of human immunodeficiency virus and hepatitis B virus

Topics:

- Human immunodeficiency virus
- Hepatitis B virus
- Blood borne pathogens
- Prevention of transmission
- Agency's Infection & Exposure Control policy
- Documentation and reporting of any infection

Statement of Understanding

By signing below I acknowledge that I have fully read and understood the exposure and infection control policy. I understand that if I have any questions or concerns about this policy, it is my responsibility to discuss this with the agency.

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date