PELA HEALTHCARE SERVICES, INC.

12808 West Airport Blvd, Ste 320
Sugar Land, TX 77478
Ph: 281.302.6475

PERSONNEL FILE

NAME: _____
LAST FIRST MI

ADDRESS: _____

_____
CITY STATE ZIP CODE

_____
CONTACT NUMBER

APPLICATION FOR EMPLOYMENT

All prospective employees will receive consideration without discrimination because of race, color, sex, age, natural origin, or handicap. All information provided here in will be kept confidential.

PERSONAL

Last Name First Middle Date

Street Address Home Phone

City, State, Zip Business Phone

S.S. # Date of Birth

Emergency Contact (person not living with you) _____ Phone #_____

Have you ever applied for employment with the Agency? ____Yes ____No

How many hours a week are you available for work? _____Minimum _____Maximum

When will you be available for work? _____

Are you legally eligible for employment in the United States? ____Yes ____No

How did you learn of our organization? ___Newspaper Ad __the Agency Employee ___Other

Are you willing to work ____Evenings ____Weekends

Position applying for: ___Admin/clerical ____Home Health Aide ____Caregiver ___LP

____RN ____Therapist (Specify) _____

APPLICATION FOR EMPLOYMENT

EDUCATION:

School Name Location of School Course of Study Years Completed Degree/ Diploma

College:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Vo-Tech or Trade:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

High School:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Other:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

EMPLOYMENT:

--List the last 5 years of your employment history, starting with the most recent employer.

1. Company Name: _____
   Address: _____
   _____
   City State Zip Code
   Name of Supervisor: _____
   Job Title and describe your work: _____
   _____
   Telephone: _____
   Dates of Employment:
   From: _____ To: _____
   Starting Pay: _____
   Ending Pay: _____
   Reason for Leaving: _____

2. Company Name: _____
   Address: _____
   _____
   City State Zip Code
   Name of Supervisor: _____
   Job Title and describe your work: _____
   _____
   Telephone: _____
   Dates of Employment:
   From: _____ To: _____
   Starting Pay: _____
   Ending Pay: _____
   Reason for Leaving: _____

3. Company Name: _____
   Address: _____
   _____
   City State Zip Code
   Name of Supervisor: _____
   Job Title and describe your work: _____
   _____
   Telephone: _____
   Dates of Employment:
   From: _____ To: _____
   Starting Pay: _____
   Ending Pay: _____
   Reason for Leaving: _____

APPLICATION FOR EMPLOYMENT

Was your last name different from your present one during the above listed jobs? ___Yes ___No

If Yes, what was your name? _____ Are you currently employed? ___Yes ___No

May we contact your present employer? _____Yes _____No

Do you have reliable transportation if required? _____Yes _____No

PROFESSIONAL REFERENCES

--Persons who can furnish information about job performance.

1. Name: _____ Telephone# _____
   Address: _____

2. Name: _____ Telephone# _____
   Address: _____

3. Name: _____ Telephone# _____
   Address: _____

GENERAL

Have you been convicted of a crime in the past 5 years, barring employment in a Home and Community support services Agency? ____Yes ____No
Conviction will not necessarily disqualify an applicant from employment.
If yes, describe in full:

_____
_____
_____

Are you capable of performing the job duties set forth in the job description? __Yes __No

If you answered No, which job requirements can you not meet?

_____
_____
_____
_____
_____

APPLICATION FOR EMPLOYMENT

CREDENTIALS/SPECIALIZED SKILLS & QUALIFICATIONS/EQUIPMENT OPERATED

List all states in which licensed giving registration and expiration date. Summarize special job-related skills and qualification acquired from employment or other experiences.

_____
_____
_____
_____
_____

SIGNATURE

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application SHALL BE GROUNDS FOR DISMISSAL.

I authorized complete investigation of all statements contained herein and herby give my full permission for the Agency to contact and fully discuss my background and history with all persons and entities listed above to give the Agency any and all information concerning my previous employment and any information they may have, and release all former employees and others listed above from all liability for any damage that my result from furnishing same to the Agency.

I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time for any lawful reason, without prior notice and with or without cause.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period shall inquire as to whether or not applications are being accepted at that time.

I the undersigned understand all policies and procedures of the company and willing to comply and abide with all rules.

***Caregiver Signature** _____ **Date** _____

PELA HEALTHCARE SERVICES, INC.

EMPLOYEE CRIMINAL HISTORY CHECK -I

I have been informed that in compliance with Texas Senate Bill 332 (House Bill 1466) passed by the 71st Legislature, this agency is required to perform criminal history checks on all employees who provide care or have access to medical records of patients in an adult facility or in a client's home.

I have been informed that the criminal history check will be conducted by the Texas Department of human Services, office of the Inspector General, on behalf of the Texas Department of Health and Texas Department of Human Services Contract Administrators.

I understand that any records received by TDHS, are privileged information and are for the exclusive use of TDHS, the Texas Department of Health, and the facility for which TDHS requested the information. The records may not be released or otherwise be disclosed to any person or agency except on court order or with the written consent of the person being investigated.

I understand that the offer of employment with this agency is conditional. This will be made permanent once the criminal history check is returned and reveals that there have been no convictions or offenses prohibiting work as outlined by the law.

* _____ _____

Caregiver Signature Date

_____ _____

Employer Signature Date

PELA HEALTHCARE SERVICES, INC.

CRIMINAL HISTORY CHECK- II

The State of Texas requires the Agency to inform the applicant of our request for a criminal check 115.54 (4). Before you are considered for employment a criminal check must be conducted. Your signature will permit us to proceed with State Regulations.

I _____, give the Agency permission to conduct a criminal history check.

I _____, have not been convicted of any offence; in the last 5 years described in the health and Safety Code 250.005 that would bar employment with the Agency.

_____

_____ _____

Caregiver Signature/Date Employer Signature/Date

_____ _____

Print Name of Caregiver Print Name of Employer

PELA HEALTHCARE SERVICES, INC.

CRIMINAL HISTORY CHECK-III

I have been informed that the agency is required to conduct Criminal History Check before making an offer of employment. I understand that I am being hired on a temporary basis until the results of the Criminal History Check are in within 72 hours. I understand that if the Criminal History Check reports a conviction of these offenses, I will be terminated. I also understand that I am being hired for the safety and welfare of the patients of this agency.

I _____, in the last 5 years, have not been convicted of any offenses listed below from the Health and Safety Code 250.005.

An offense under,
Chapter 19, Penal Code (criminal homicide)
Chapter 20, Penal Code (Kidnapping and false imprisonment)
Section 21.11, Penal Code (Indecency with a child)
Section 25.031 Penal Code (agreement to abduct from custody)
Section 25.06 Penal Code (Solicitation of a child)
Section 25.11 Penal Code (sale or purchase of a child)
Section 28.02 Penal Code (arson)
Section 28.02 Penal Code (robbery)
Section 29.03 Penal Code (aggravated robbery)

Will bar possible employment.

The offense listed below may potentially bar employment, however may be subject to an administrative review.

An offense under:
Chapter 22, Penal Code (assault offenses)
Chapter 30, Penal Code (burglary and criminal trespass)
Chapter 31, Penal Code (theft)
Chapter 46, Penal Code (weapons)
A felony violation of statute to control the possession or distribution of a substance Included in chapter 481, Health and Safety Code (Texas Controlled Substance Act)

Chapter 32, Penal Code (fraud)
Section 21.07, Penal Code (public lewdness)
Section 21.08, Penal Code (public Indecency).

_____
Caregiver Signature/Date

_____
Employer Signature/Date

PELA HEALTHCARE SERVICES, INC.

Nurse – Aide Registry Check

The State of Texas requires the Agency, Inc to inform the applicant of our request for Nurse Aide Registry Check, before you are considered for employment. Your Signature will permit us to proceed with State regulations.

I _____, give the Agency permissions to conduct a Nurse Aide Registry Check.

I _____, have no offense in the Nurse Aided Registry Check (established under Health and Safety code, chapter 253) as unemployable due to a finding that I have committed an act constituting "reportable conduct".

_____ _____

Caregiver Signature/Date Employer Signature/Date

_____ _____

Print Name of Caregiver Print Name of Employer

PELA HEALTHCARE SERVICES, INC.

ORIENTATION TO PERSONNEL POLICIES

Date: _____

AGENDA ITEMS FOR DISCUSSIONS:

1. Orientation of all personnel to the policies and objectives of the Agency
2. Periodic Evaluation of employee performance
3. Personnel Policies
4. Disciplinary actions & procedures
5. Job description for each position
6. Safety/Assignment
7. Change in client conditions
8. Use of form
9. Infection control
10. Hepatitis B & Blood Bone Pathogen

This is to acknowledge that I have been oriented on the above Agency Policies.

_____ _____

Caregiver Signature Employer Signature

PELA HEALTHCARE SERVICES, INC.

EMPLOYMENT VERIFICATION FORM

NAME OF EMPLOYEE: _____
Last First MI

Criminal History: _____

_____

_____

Date Verified: _____
Outcome: _____

_____

Nurse Aide Registry: _____

_____

Date Verified: _____
Outcome: _____

_____

Employee Misconduct: _____

_____

_____

Date Verified: _____
Outcome: _____

_____

PREVIOUS EMPLOYMENT:

Employer Name: _____
Address: _____

_____

City State Zip Code

Employment Date: _____ _____
Start End

Date Verified: _____
Reason for Leaving: _____

_____

Outcome: _____

_____

_____

Employer Signature

PELA HEALTHCARE SERVICES, INC.

ILLEGAL REMUNERATION/HOME HEALTH NON SOLICITATION

It is a policy of the Agency that no employee shall intentionally or knowingly offer to pay or agree to accept any direct or indirect, overtly or covertly in cash or in kind, to or from any person, firm, association of persons, partnership, or corporation for securing or soliciting patients or patronage.

Any employee found to be in violation of this policy would be terminated, and appropriate State officials will be notified, since this is an offense in the State of Texas.

Policy: It shall be the policy of this agency to follow the state and our staffs, employees and representative are not to solicit patients from other agencies.

This agency shall enforce a written policy to ensure compliance of the agency and its employees and contractors with the Health and Safety Code, action 161.091 relating to the prohibition of illegal remuneration for securing patients or patronage.

Violation of this policy may result in termination of employment or Contractual Arrangement

Caregiver Signature _____ Date _____

Employer Signature _____ Date _____

PELA HEALTHCARE SERVICES, INC.

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION AND CLIENT'S MEDICAL RECORDS

The Agency will respect the patient's rights to confidentiality of personal and medical information in accordance with applicable state, federal, and HIPAA regulations. All employees will be provided with information during orientation regarding respect of the patient's privacy and confidentiality of information obtained by the employee during the provision services and through contact with the client's medical record. Medical records will be secured at the Agency's office in file cabinets. In the event of agency closure, see Agency Closure Policy. All office and field-based employees will maintain confidentiality of medical information and records. Access to medical records will be limited to the minimum amount necessary to accomplish the stated purpose according to professional judgment. Records will not be removed from the office. The patient's or designated legal representative's written consent will be required for the release of information as indicated in HIPAA privacy guidelines.

A patient data sheet may be kept in the patient's home for the purpose of communication between all health care providers and family and for quick reference on patient's status. Example of items listed might include: vital signs, glucose levels, and concern of problems. The patient and/or authorizes family members will be educated by the skilled nurse or therapist upon admission re: the confidentiality of patient information and the need to protect it from loss or unauthorized use. To further ensure confidentiality, any and all patient protected health information transported to and from patient's homes must be safeguarded according to the agency's policies, see Transporting of Notes and Other Protected Health Information Policy.

If a patient transfer to another health agency or healthcare setting, a transfer form will be utilized per policy. Prior to beginning employment, personnel will be requested to sign an 'Agreement of Confidentiality' attesting to their understanding of, and agreement to maintenance of confidentiality of all protected health information and other privacy and security requirements required by HIPAA.

AGREEMENT OF CONFIDENTIALITY

I _____ understand that in the performance of my duties, I may have contact with sensitive and confidential information about patients receiving services from the Agency. I will respect each patient's right to privacy and will hold in confidence any private or medical information of which I may become knowledgeable of in carrying out my assigned duties.

I further understand that should I fail to honor the aforementioned policies and confidentiality information about patients, other employees, or the agency, such breach of confidentiality may result in the implementation of the Disciplinary procedure up to and including possible immediate DISMISSAL from employment at the Agency, and potentially, expose me to fines and other sanctions defined in the enforcement section of the HIPAA regulations.

Caregiver Signature/Date _____ Employer Signature/Date_____

PELA HEALTHCARE SERVICES, INC.

AGREEMENT FOR EMPLOYEE PROTECTION OF PRIVATE HEALTH INFORMATION

I _____ understand that in performance of my duties, I may possess sensitive and confidential information about patients receiving services from the Agency. In recognition of the sensitive nature of this information and the prevailing privacy laws, I agree to abide by the following:

1. If I have a fax machine in my home and receive patient information on the fax, I will place the fax machine in a private location and protect any PHI transmitted to me regarding patients in my care

2. Upon discharge of a patient, I will return any patient information in my possession to the Agency for destruction.

3. In transporting patient information to the patient's home or to the Agency, I understand that I must carry the information in a closed system and in a locked vehicle.

I further understand that should I fail to honor the requirements above, that this breach may be cause for my termination of employment with the agency and potentially, expose me to fines and other sanctions defined in the enforcement section of the HIPAA regulations.

Caregiver Signature _____ Date _____

Employer Signature _____ Date _____

PELA HEALTHCARE SERVICES, INC.

Employee Misconduct Registry Rules

The State of Texas requires the Agency to inform the applicant of our request for employee misconduct checks in the Employee Misconduct Registry. Before you are considered for employment, employee misconduct checks must be conducted. Your signature will permit us to proceed with state regulations.

I _____, give the Agency permissions to conduct an Employee Misconduct check on me.

I _____, have no offense in the Employee Misconduct Registry (established under Health and Safety code, chapter 253) as unemployable due to a finding that I have committed an act constituting "reportable conduct".

_____ _____

Caregiver Signature/Date Employer Signature/Date

_____ _____

Print Name of Caregiver Print Name of Employer

PELA HEALTHCARE SERVICES, INC.

PRIMARY HOME CARE EMPLOYEE AGREEMENT

I, _____, do hereby agree that as an employee of the Agency, I will follow all the instructions given to me in my tasks assignment sheet. I agree that I will not perform any act of administering any medication unless the client individual plan of care authorizes me to assist in administering medication.

I have read and understand the agency policies and procedures and I have also been given a copy of my job description. I understand and agree to them as a condition of employment. I have been instructed on agency's safety and emergency services. I understand that failure to comply with both procedures may cause injury to me or others or in unacceptable work performance and that violation of any rules could result in termination of employment.

I have been informed and fully understand to report suspected or known cases of abuse and neglect. I have been informed and do fully understand that I will never assume that a given client is incapable of becoming physically aggressive or of injuring an employee. I understand that my request for services rendered will not be processed until a properly completed time sheet is submitted by me to the Agency at the appointed time. I have been informed and understand if I perform negligently, fail to work or quit without notice, I may be liable for harm suffered by the client as a result of these actions and can be subject to prosecution in the State of Texas for elder abuse.

I understand that PELA HEALTHCARE SERVICES, INC receives clients from the State with different hours and tasks, and services/employment are TEMPORARY because client may transfer care to another agency, lost Medicaid eligibility, hospital/nursing home admission, dead, and/or client may choose that he/she no longer need our services due to your absences, lateness or not satisfied with your work. As a result, PELA Healthcare Services, Inc will not be held responsible for your employment.

Upon termination with the present client, I do hereby agree that as an employee of the Agency, I am responsible for notifying the director of Primary Home Care that I am available for re-assignment. If I fail to do so, it is agreed by both parties that I have voluntarily separated myself from employment with the Agency.

_____
Caregiver Signature/Date

_____
Employer Signature/Date

PELA HEALTHCARE SERVICES, INC.

AGREEMENT FOR LIABILITY

I_____, understand that I am not to transport my client in my vehicle, client's vehicle or any other vehicle because it is against the policy of the company.

That I will be liable for any consequences whenever I chose to transport my client in my vehicle, clients vehicle or any other vehicle.

K_____
Caregiver Signature/Date

_____
Employer Signature/Date

PELA HEALTHCARE SERVICES, INC

POLICY AND PROCEDURE FOR CLIENT CREDIT CARE/CASH (SHOPPING)

I _____ agrees as an employee of PELA HEALTHCARE SERVICES, INC that I must complete client's task (shopping) according to client's list and return receipt, credit card or cash balance to client. I am NOT allowed to purchase personal item(s) with client's credit card or cash. Accepting or taking money or possessions from aged or disabled elder is strictly prohibited.

I understand and agree that any form of dishonest act or criminal offense is strictly prohibited by the Agency and will result in immediate termination of employment, and prosecution by the State.

_____
Caregiver Signature/Date

_____
Employer Signature/Date

PELA HEALTHCARE SERVICES, INC.

PROVIDER JOB DESCRIPTION

QUALIFICATIONS:

1. Be at least 18 years of age or, if less than 18 years of age, must be a high school graduate or enrolled in a vocational education program.
2. Experience of at least 6 months
3. Ability to follow oral and written instructions
4. Ability to keep simple records
5. Experienced in understanding and caring of the aged and disabled convalescing person
6. Not legal parent, foster parent, or spouse of a parent of a minor who receives the service
7. Not the parent of the individual who receives the service, except for FC services
8. Not designated by a HHSC case manager on HHSC' authorization for community care services form as "Do not hire"

JOB DESCRIPTION:

The following tasks are inclusive, but not limited to be performed by the provider:

1. BATHING
2. DRESSING
3. EXERCISING
4. GROOMING
5. ROUTINE HAIR/SKIN CARE
6. TOILETING
7. TRANSFER/AMBULATION
8. CLEANING
9. LAUNDRY
10. MEAL PREPARATION
11. ESCORT
12. SHOPPING

I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT.

Caregiver Signature/Date

Employer Signature/Date

PELA HEALTHCARE SERVICES, INC.

The agency staff will implement appropriate actions for clients in an emergency situation.

PROCEDURE:

1. MEDICAL EMERGENCY/LIFE THREATENING SITUATION:
   a. Call emergency rescue services 911 or direct member of the family to call
   b. Stay with the client until the emergency rescue service arrives
   c. Call administrative staff and report the emergency situation, only after help has arrived.

2. Change in the client condition:
   a. Any changes in the client's conditions will be reported immediately to Administrative staff
   b. The Administrative staff will determine the appropriate intervention for the client and instruct the Caregivers.

3. DEATH OF A CLIENT:
   a. If the Client dies when the Caregiver is present, or is found dead by the Caregivers, Administrative staff is to be contacted immediately. Administrative staff will instruct the Caregivers in appropriate interventions, contact family member.

4. If the Client does not answer the door and the Caregiver has reason for concern about the Clients safety:
   a. Call the Administrative staff and report the situation
   b. Summons appropriate assistance as directed by Administrative staff to gain entry into the home to verify that the client is safe.

5. If the caregiver is injured in any way while on the job or in between shifts and the injury is possible to prevent you from carrying out your responsibilities on the job or showing up to work, you must contact Pela Healthcare Services, Inc. immediately or as soon as possible after the injury occurs within 1 hour at 281-302-6475 or 832.577.5166.

Caregiver Signature/Date

Employer Signature/date

PELA HEALTHCARE SERVICES, INC.

Employee Requirements

As a Representative of Pela Healthcare Services, Inc your appearance and behavior in the community is very important to us. The following requirements are expected:

1. Wear clean and appropriate clothes (**scrubs uniform**) to work.
2. Turn your cell phone off while working with clients, and never answer your phone in client's house.
3. Not have friends, pets, or family members accompany you when you're with a client unless authorized by the office.
4. You are prohibited to ask to borrow things from the client.
5. Should any misunderstanding or problem arise between you and your client, please call the office for advice.
6. Never make call on the client's phone unless it's emergency.
7. Do not introduce new activities to the client, unless authorized by the client's doctor.
8. Do not report to work if you are under the influence of alcohol and/or drugs.
9. You are not allowed to bring alcohol or any intoxication beverages as well as any illegal drugs during your time on duty.
10. Smoking is not allowed inside the client's home.
11. Carrying of unauthorized or concealed weapons is not allowed.

Caregiver Signature/Date

Employer Signature/Date

PELA HEALTHCARE SERVICES, INC.

Employee/Caregiver agrees for the need to have a very flexible schedule that will allow him/her to work any day or hours of the day weekly.

Employee agrees and understands that he/she may be required to travel up to 50 miles to work a two hour shift and then travel another 50 miles to work for another two hours shift in any given day during any time of the day, if he/she needs to get up to 40 hrs a week.

Employee agrees and understands that this position is part time and that there is therefore no guaranteed permanent employment of working 40 hours each week with agency clients.

Employee understands and agrees that he/she will only be scheduled for a minimum of total hours approved to his/her client by the state. The agency cannot predict the health or the personal requests of its clientele, so changes to employee schedule may happen unexpectedly for providing consistent hours weekly upon state order.

Employee understands and agrees that if assigned to work for a client and fail to comply with scheduled hours/tasks, and/or agency receives complaints from your client/client's family; the agency will assign you to another client if needed, and if such behavior continues, employment will be terminated by the agency.

Truth of All information Given by Applicant. I hereby state that all the information that I provide on this application or any other documents filled out in connection with my employment, and in any interview is true and correct. I have withheld nothing that would, if disclosed, affect this application unfavorably. I understand that if I am employed and any such information is later found to be false in any respect, I will be dismissed.

Employee understands and agrees that he/she is in a probationary period of 3 months when starting care with Pela Healthcare Services, Inc.

DO NOT SIGN UNTIL YOU HAVEREAD & UNDERSTAND THE ABOVE STATEMENT AND AGREEMENT.

✓ **I hereby acknowledge that I have read the above statements and understand the same.**

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

Caregiver Signature/Date

Employer Signature/Date

PELA HEALTHCARE SERVICES, INC.

Pela Healthcare Services, Inc. is committed to providing high quality care to our client in their home.

NOTE: Regular attendance and punctuality are essential for our company to help assist our clients achieve the highest level of care. Therefore, we have developed the following of attendance policy;

1) **Notify Agency**
   It is important that the office be notified immediately of the following:
   a. Requests from client for a change in type of services we provide.
   b. Significant changes in a client's condition (i.e. they get admitted to hospital.)
   c. Schedule or shift changes (i.e. if the client calls you to cancel an appt.)
   d. New appointments for services that clients make directly with you.
2) **Tardy**
   Tardiness occurs when an employee is not present at work place on scheduled time. Employees are responsible to call agency and client to notify of any delay.

3) **No call/No show**
   In case of emergency, employees must report their absences. If unable to report to work, notify the agency at 4-6 hrs prior to scheduled time. Any employee who fails to comply is voluntary terminates his/her employment. The agency's goal is to provide quality care including safety of our clients.

4) **Resignation**
   All employees are required to give 2 weeks written notice prior to leaving the agency. Failure to do so, your last paycheck will be held.

5) **Workload**
   The number of clients served by Pela Healthcare Services, Inc changes all of the time. There may be gaps in time when your client services ends. Employees willing to continue with Pela Healthcare Services, Inc are required to contact the agency to reassign another client. We try to assign another client, however if offered 2 clients and you decline, Pela Healthcare Services will consider your employment with the agency terminated and will not be held responsible.

Caregiver Signature/Date

Employer Signature/Date

DPS Computerized Criminal History (CCH) Verification

I, _____, have been notified that a Computerized
EMPLOYEE NAME (Please print)
Criminal History (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB information I supply.

Because the name based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization (as listed below) conducting the criminal history check is not allowed to discuss any information obtained using this method, therefore the agency may offer the opportunity to have a fingerprint search performed to clear any misidentification based on the name search, if the search provides a criminal report I know could not be mine.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from this agency, make an online appointment, submit a full and complete set of my fingerprints, and pay a fee of $9.95 to the fingerprinting services company, L1 Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

_____
Caregiver Signature

_____
Date

_____
Agency Name (Please print)

_____
Employer Name (Please print)

_____
Employer Signature

_____
Date

Check and initial each Applicable Space

CCH Report Printed:

Yes ___ No ____ _____ Initial

Purpose of CCH: _____

Hire ____ Not Hired _____ _____ Initial

Date Printed: _____ _____ Initial

Destroyed Date: _____ _____ Initial

Retain in your files

PELA HEALTHCARE SERVICES, INC.

Agreement upon Hire

Please indicate how you heard about PELA Healthcare Services, Inc.

Client Referral (Client's name): _____

Friend/Employee Referral (Print Name): _____

Other: _____

Please be advised that when client or client's family refers you to work for him/her and eventually terminates your services, or client leaves our agency, PELA Healthcare Services, Inc. will not be held responsible for your continuous employment with the agency.

_____ _____
Caregiver Signature/Date

_____
Employer Signature/Date

PELA HEALTHCARE SERVICES, INC.

Date: August 26, 2019

To: All employees

Subject: Information Letter (Hourly rate increase)

Effective September 1, 2019, Texas Health and Human Services Commission (HHSC) has mandate all home health agency to pay all employees (attendants) or contractors of a provider for Community Attendant Services Providers (CAS), Family care Providers (FC), Primary Home Care Program Providers (PHC), etc. a base wage of at least $8.11 per hour.

Reference: Texas Administrative Code, Title 40, Chapters 49 and 41 or contact HHSC 512.438.2188.

For further questions, do not hesitate to contact agency administrator at 281.302.6475

Caregiver Signature/Date

Employer Signature/Date

PELA HEALTHCARE SERVICES, INC.

HOURLY WAGES AGREEMENT

EMPLOYEE NAME: _____

DATE OF HIRE: _____

HOURLY WAGES: _____

PAY PERIODS: _____

_____
Caregiver Signature/Date

_____
Employer Signature/Date

EMPLOYEE AUTHORIZATION FOR AUTOMATIC DEPOSIT

(For Payroll Purposes Only)

Instructions: *Please print clearly. Complete the form below and submit to your employer's Payroll Department.*

I hereby authorize **PELA HEALTHCARE SERVIES, INC.** (Employer) to initiate credit entries, and, if necessary, debit entries and adjustments for any credit entries in error, to the account indicated below. I also authorize the financial institution indicated below to credit and/or debit the same to such accountant. I recognize that sometimes there may be delays in crediting my account due to banking procedures or errors. For which **PELA HEALTHCARE SERVICES, INC.** (Employer) cannot be held responsible.

BEGIN AUTOMATIC DEPOSIT

(Checking OR Savings Account)

Please start Automatic Deposit to my:

Checking Account #_____ Savings Account #_____

Bank Routing Number_____

Amount to be deposited: Net Pay Check____ OR Other Amount: $_____

Name of Financial Institution _____

City, State, Zip Code_____

Bank Branch Phone #_____

NOTE: FOR CHECKING ACCOUNT, YOU MUST ATTACH A BLANK VOIDED CHECK TO THIS FORM

Caregiver Name (Print): _____

Caregiver Signature/Date: _____

PELA HEALTHCARE SERVICES, INC.

EMPLOYEE INFORMATION

(For Payroll Purposes Only)

Name: _____

Address: _____

_____

City State Zip Code

Social Security Number: _____ DOB: (mm-dd-yyyy) _____

U.S. Citizen: ____ Yes _____ No I-9 Form on File: ____ Yes _____No

Work Authorization Expiration: _____ Gender: ☐M ☐F

Telephone: (Cell): _____ Home: _____

Number of Dependents (Tax Exemptions): _____ Marital Status: ☐M ☐S

Date of Hire: (mm-dd-yyyy) _____

Pay Rate: $_____ (circle one) per hr/wk/visit/admission/month/other

Frequency of pay: ☑ Biweekly (Every other Friday)

*Caregiver Signature: _____ Date: _____

Employer Name: _____

Employer 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

2020

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 widow(er))
☐ **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, when to use the online estimator, 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) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

If your 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 and 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)

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.

2. State Employer ID Number (Optional):

3. Employer Name:

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

5. Employer City (if US):

6. State (if US):

7. ZIP Code (if US): –

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

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶**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 08/31/2019

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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
Health and Human Services

Form 1734
June 2015-E

Consumer Directed Services (CDS)

Service Provider and Employer Certification of Relationship Status for CDS

Service Provider Name	Maiden Name — if applicable
Individual Receiving Services	Employer Name
Service Provider's Relationship to Individual	Designated Representative (DR) — if applicable
Service Provider's Relationship to Employer	Service Provider's Relationship to DR

Service Provider: Place a check mark in the column that describes your status and relationship.

Section 1: All Programs

All service providers must answer the following questions.

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you under age 18?	☐	☐	
2.	Are you the individual's legally authorized representative (LAR)? (That is, the individual's natural parent, legal/adopted parent, stepparent or managing conservator if the individual is under age 18 [a minor], or the court-appointed guardian of an individual of any age.)	☐	☐	
3.	Are you the spouse* of the individual's LAR? (That is, the spouse of the individual's natural parent, legal/adopted parent, stepparent or managing conservator if the individual is under age 18 [a minor], or the spouse of the court-appointed guardian of an individual of any age.)	☐	☐	
4.	Are you the spouse* of the individual? (Consumer Managed Personal Attendant Services (CMPAS) service providers mark this item Not Applicable (N/A).)**	☐	☐	☐
5.	Are you the spouse* of the employer? (CMPAS service providers mark this item N/A.)**	☐	☐	☐
6.	If the individual is a Texas Department of Family and Protective Services (DFPS) foster child or adult, are you the individual's foster parent? (If the individual is not a DFPS foster child/adult, mark this item N/A.)	☐	☐	☐
7.	If the individual is a DFPS foster child or adult, are you the spouse* of the individual's foster parent? (If the individual is not a DFPS foster child/adult, mark this item N/A.)	☐	☐	☐
8.	Are you the power of attorney (attorney in factor agent) for financial responsibilities on behalf of the individual?	☐	☐	
9.	Are you the DR or the CDS employer for the individual?	☐	☐	
10.	Are you the spouse* of the employer's DR?	☐	☐	

*Spouse is defined as either a legal marriage or a marriage without formalities (common law marriage) in accordance with the Texas Family Code.

**The spousal relationship in questions 4 and 5 is not applicable for CMPAS. (The spouse may be employed.)

Section 2: Medically Dependent Children Program (MDCP)

If providing services in the MDCP program, please answer the following additional questions. (Mark these items N/A if the individual is not enrolled in MDCP.)

	Service Provider Status and Relationship	Yes	No	N/A
11.	Are you the parent or primary caregiver of the individual?	☐	☐	☐
12.	Are you the spouse* of the parent or primary caregiver?	☐	☐	☐

Section 3: Home and Community-based Services (HCS) and Texas Home Living (TxHmL)

If providing respite, adaptive aids or behavioral support services in the HCS or TxHmL program, please answer the following additional questions, as applicable. (Mark these items N/A if the individual is not receiving an applicable HCS or TxHmL service.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Are you a person living in the same household as the individual? (Applies to respite services.)	☐	☐	☐
2.	Are you the spouse* of a person living in the same household as the individual? (Applies to respite services.)	☐	☐	☐
3.	Are you a person related to the individual within the fourth degree of consanguinity or within the second degree of affinity? (Applies to adaptive aids and behavioral support services.)	☐	☐	☐

Section 4: Community Living Assistance and Support Services (CLASS) — Respite Service Providers Only

If providing respite services in the CLASS program and the primary caregiver is the Community First Choice (CFC) Personal Assistance Services/Habilitation (PAS/HAB) service provider, please answer the following additional question. (Mark this item N/A if the individual is not receiving CLASS respite services. Also mark this item N/A if the individual is receiving CLASS respite services, but the primary caregiver is not the CFC PAS/HAB service provider.)

	Service Provider Status and Relationship	Yes	No	N/A
1.	Do you live in the same household as the individual?	☐	☐	☐

Section 5: Primary Home Care (PHC), Community Attendant Services (CAS) and Family Care (FC)

If providing PHC, CAS or FC, please answer the following additional questions. (Mark these items N/A if the individual is not enrolled in PHC, CAS or FC.)

	Service Provider Status and Relationship	Yes	No	N/A
.	Are you the primary caregiver for the individual?	☐	☐	☐
.	Are you the spouse* of the primary caregiver for the individual?	☐	☐	☐

Employer and Service Provider Certification

Employer: Place a check mark to determine eligibility for employment in CDS. ☐

If any item above is marked Yes, the service provider is not eligible to be a paid service provider (employee, contractor or vendor) in the CDS option for this individual. If every item above is marked No or N/A, the service provider meets relationship eligibility for employment in CDS for this individual unless contraindicated by requirements of the individual's program. (N/A only applies where indicated.) The employer and the service provider certify that the responses are accurate.

Employer check one: The service provider ☐ *is* or ☐ *is not* eligible for employment in CDS for this individual.

Printed Employer Name	Signature — Employer	Date
Printed Service Provider Name	Signature — Service Provider	Date