EMPLOYMENT APPLICATION

& PRE-HIRE SCREENING PACKET

Hopeful Assurance Home Health Care LLC

10 Canebrake Blvd, Suite 110-094 | Flowood, MS 39232 | 769-366-9256

Please complete all sections in ink or electronically. Do not provide a Social Security number, date of birth, medical diagnosis, or other sensitive information on this application unless specifically requested on a separate secure form. Incomplete information may delay review.

APPLICANT INFORMATION

Applicant Name	**Date Submitted**
Position Applied For	**Preferred Start Date**
Primary Phone	**Email Address**

An Equal Opportunity Employer

Employment decisions are made without unlawful discrimination and are based on qualifications, job requirements, and agency needs.

APPLICATION FOR EMPLOYMENT

Applicant information and position preferences

PERSONAL INFORMATION

Legal Name | **Preferred Name**

Street Address | **City / State / ZIP**

Primary Phone | **Alternate Phone**

Email | **Best Contact Method**

☐ Are you at least 18 years old? Yes ☐ No

☐ Are you legally authorized to work in the United States? Yes ☐ No

☐ Will you now or in the future require employment sponsorship? Yes ☐ No

Proof of identity and authorization to work will be requested after an offer of employment, as required by federal law.

POSITION AND AVAILABILITY

Position Applied For | **Date Available**

Employment Desired | **Desired Hourly Rate**

☐ Full-Time ☐ Part-Time ☐ PRN / On-Call

Available Start Time | **Available End Time**

Days available: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Shift availability: ☐ Days ☐ Evenings ☐ Overnights ☐ Weekends ☐ Holidays

☐ Are you able to reliably report to assigned client locations? Yes ☐ No

☐ Do you have reliable transportation for job-related travel? Yes ☐ No

☐ If driving is an essential duty, do you hold a valid driver license? Yes ☐ No ☐ Not applicable

QUALIFICATIONS AND CAREGIVING EXPERIENCE

LICENSES, CERTIFICATIONS, AND TRAINING

Credential / Training	Issuing Organization	Number (optional)	Expiration	Verified

Current credentials (check all that apply): ☐ PCA ☐ CNA ☐ CPR ☐ First Aid ☐ Medication Reminders Training ☐ Other

CAREGIVING BACKGROUND

Experience with (check all that apply): ☐ Older adults ☐ Physical disabilities ☐ Dementia / memory loss ☐ Developmental disabilities ☐ Hospice / end-of-life support ☐ Respite care ☐ Companionship ☐ Personal care / ADLs ☐ Homemaker services

Skills you are prepared to perform within agency policy and your training: ☐ Bathing ☐ Grooming ☐ Dressing ☐ Toileting ☐ Transfers ☐ Ambulation ☐ Meal preparation ☐ Light housekeeping ☐ Laundry ☐ Errands ☐ Observation and reporting ☐ EVV / electronic documentation

Briefly describe your caregiving experience and the types of clients you have served:

_____

_____

_____

_____

EDUCATION AND EMPLOYMENT HISTORY

EDUCATION

School / Program	City & State	Diploma / Degree / Certificate	Completed?

EMPLOYMENT HISTORY - MOST RECENT EMPLOYER

Employer Name | **Phone**

Employer Address | **Supervisor**

Job Title | **Dates Employed (MM/YYYY - MM/YYYY)**

Starting Pay | **Ending Pay**

Primary Duties | **Reason for Leaving**

☐ May we contact this employer? Yes ☐ No If no, explain: _____

EMPLOYMENT HISTORY - PREVIOUS EMPLOYER

Employer Name | **Phone**

Employer Address | **Supervisor**

Job Title | **Dates Employed (MM/YYYY - MM/YYYY)**

Starting Pay | **Ending Pay**

Primary Duties | **Reason for Leaving**

☐ May we contact this employer? Yes ☐ No If no, explain: _____

ADDITIONAL EMPLOYMENT AND REFERENCES

ADDITIONAL EMPLOYER

Employer Name | **Phone**

Employer Address | **Supervisor**

Job Title | **Dates Employed (MM/YYYY - MM/YYYY)**

Primary Duties | **Reason for Leaving**

☐ May we contact this employer? Yes ☐ No If no, explain: _____

PROFESSIONAL REFERENCES

List people who can speak to your work performance. Do not list relatives unless they directly supervised your work.

Name	Relationship / Company	Phone	Email	Years Known

EMERGENCY CONTACT - COMPLETED AFTER HIRE

This section is optional during application and may be completed after hire for personnel records.

Emergency Contact Name

Relationship

Primary Phone

Alternate Phone

JOB REQUIREMENTS AND APPLICANT DISCLOSURES

ESSENTIAL JOB FUNCTIONS

Personal care positions may require standing, walking, bending, reaching, assisting with mobility, performing light housekeeping, documenting services, communicating changes, and traveling to client homes. Specific duties depend on the assigned service plan and job description.

☐ Can you perform the essential functions of the position, with or without reasonable accommodation? Yes ☐ No

☐ Do you need information about requesting a reasonable accommodation? Yes ☐ No

Do not disclose a diagnosis or medical history on this application. Accommodation requests are handled separately and confidentially.

PRIOR EMPLOYMENT AND ELIGIBILITY

☐ Have you previously worked for Hopeful Assurance Home Health Care LLC? Yes ☐ No

If yes, dates and position: _____

☐ Are you subject to any agreement that may restrict your ability to perform this job? Yes ☐ No

If yes, explain without sharing confidential information: _____

BACKGROUND SCREENING NOTICE

Final candidates may be required to complete fingerprint-based criminal history screening, registry checks, identity and employment verification, driving record review when driving is job-related, and other screenings permitted or required by law. A record does not automatically disqualify an applicant; eligibility will be evaluated according to applicable requirements and the duties of the position.

☐ I understand that additional screening forms and notices may be required.

ADDITIONAL INFORMATION

Describe any additional experience, languages, scheduling strengths, or qualifications relevant to this position:

_____

_____

_____

_____

_____

APPLICANT CERTIFICATION AND AUTHORIZATION

- I certify that the information provided in this application is true, complete, and accurate to the best of my knowledge. I understand that material omissions, misrepresentations, or falsified information may result in withdrawal of an offer or termination of employment.
- I authorize Hopeful Assurance Home Health Care LLC to verify information related to my qualifications, education, employment history, references, licenses, certifications, and job-related eligibility. I authorize persons and organizations contacted for legitimate employment purposes to provide relevant information, subject to applicable law.
- I understand that completion of this application does not guarantee employment and does not create a contract of employment. Unless a written agreement signed by an authorized representative states otherwise, employment is at will, meaning either the employee or the agency may end the employment relationship at any time, with or without cause or advance notice, subject to applicable law.
- I understand that, if selected, I must comply with agency policies, complete required orientation and training, maintain confidentiality, accurately document services, follow Electronic Visit Verification procedures when applicable, and report suspected abuse, neglect, exploitation, incidents, and safety concerns as required.
- I understand that an offer may be conditioned on successful completion of required screening and verification steps.

Applicant Printed Name **Applicant Signature**

Date **Application Received By**

VOLUNTARY SELF-IDENTIFICATION

Hopeful Assurance Home Health Care LLC is an equal opportunity employer. Applicants may voluntarily identify a need for language assistance or an accommodation in the application process. This information is not used to unlawfully discriminate.

☐ I request language assistance. ☐ I request an accommodation for the application or interview process. ☐ No assistance requested.

Preferred contact for assistance: _____

PRE-EMPLOYMENT SCREENING AUTHORIZATION

Complete only when requested by the agency

This authorization supplements, and does not replace, any separate notices or consent forms required by a screening vendor, government agency, or applicable law. Sensitive identifiers should be submitted only through the secure process provided by the agency.

APPLICANT INFORMATION

Full Legal Name

Other Names Used for Employment Records

Current Address

City / State / ZIP

Phone

Email

AUTHORIZATION

I authorize Hopeful Assurance Home Health Care LLC and its authorized agents to obtain and verify job-related information for employment purposes, including criminal history information, fingerprint results, abuse and neglect registry information, sex offender registry information, professional license or certification status, employment and education history, professional references, and motor vehicle records when driving is an essential job duty. I understand that additional disclosures and authorizations may be provided separately when required.

I understand that I may be asked to provide identifying information, including date of birth or Social Security number, through a separate secure process solely for identity verification and screening. I authorize release of relevant results to Hopeful Assurance Home Health Care LLC to the extent permitted by law.

I certify that the identifying information I provide for screening is accurate. This authorization remains valid during the hiring process and, if permitted by law and required by agency policy, for periodic rescreening during employment. I may request information about the screening process from the agency.

Applicant Printed Name

Applicant Signature

Date

Witness / Agency Representative

HOPEFUL ASSURANCE UNIVERSITY

New Hire Orientation 101

Welcome to Hopeful Assurance

Course Length	30 minutes
Audience	All newly hired employees
Delivery	Instructor-led or self-paced
Completion Standard	Participation, required ClassMarker assessment, and signed acknowledgment

“Hope, assurance, and compassionate care—one home, one participant, one family at a time.”

Course-at-a-Glance

Time	Topic	Method
3 min	Welcome and purpose	Opening remarks
5 min	Mission, vision, and core values	Presentation and discussion
8 min	Role of the non-medical caregiver	Examples and guided discussion
5 min	Professional expectations	Policy overview
4 min	Person-centered care and participant rights	Scenario review
5 min	ClassMarker assessment and acknowledgment	Individual completion

Instructor Preparation

- ☐ Review this module before presenting it.
- ☐ Have the employee handbook, attendance sheet, and acknowledgment form available.
- ☐ Explain that this course introduces agency expectations but does not replace detailed policies or job-specific instruction.
- ☐ Allow employees to ask questions and direct policy questions to the Administrator or designated supervisor.

Learning Objectives

1. Explain the mission, vision, and values of Hopeful Assurance Home Health Care LLC.
2. Describe the role and limits of a non-medical caregiver.
3. Identify basic expectations for attendance, appearance, communication, and conduct.
4. Explain person-centered care and the importance of dignity, choice, privacy, and independence.
5. Identify when concerns must be reported to a supervisor.

Welcome to Hopeful Assurance

Welcome to Hopeful Assurance Home Health Care LLC. You are joining a team committed to compassionate, dependable, and respectful non-medical home care. Every employee contributes to the safety, comfort, independence, and quality of life of the people we serve.

Our standard: Provide every participant with the same respect, patience, and professionalism you would expect for someone you love.

Our Mission

To provide compassionate, dependable, and high-quality non-medical home care services that promote independence, dignity, safety, and an improved quality of life for every participant we serve.

Our Vision

To be a trusted Mississippi home care provider known for compassionate service, dependable caregivers, strong training, and respect for every participant and family.

Our Core Values

Compassion	We respond with kindness, patience, and understanding.
Respect	We honor each participant's dignity, choices, culture, privacy, and personal space.
Integrity	We are truthful, responsible, and ethical, even when no one is watching.
Excellence	We follow the care plan, improve our skills, and aim for high-quality service.
Accountability	We take responsibility for our attendance, conduct, documentation, and assigned duties.
Teamwork	We communicate appropriately and support safe, consistent care.

The Role of a Non-Medical Caregiver

A non-medical caregiver supports the participant with approved services listed in the care plan. The caregiver does not diagnose conditions, prescribe treatment, change medications, or perform tasks outside the employee's training and authorization.

Common Responsibilities

- Assisting with approved activities of daily living, such as bathing, dressing, grooming, toileting, mobility, and eating.
- Supporting instrumental activities, such as light housekeeping, meal preparation, errands, and companionship, when included in the care plan.
- Observing and promptly reporting changes, concerns, hazards, incidents, refusals, or suspected abuse, neglect, or exploitation.
- Completing accurate service documentation and time records.
- Protecting confidentiality and maintaining professional boundaries.

Tasks You Must Not Perform Without Authorization

- Diagnosing a participant's illness or condition.
- Changing a medication dose or schedule.
- Performing nursing procedures or medical treatments outside your role.
- Changing the care plan on your own.
- Using the participant's money, property, phone, vehicle, or personal accounts for your own benefit.
- Accepting loans, borrowing money, or entering personal business arrangements with a participant.

PROFESSIONAL EXPECTATIONS

How We Represent Hopeful Assurance

Expectation	Required Practice
Attendance and punctuality	Arrive on time, remain for the full authorized shift, and follow call-off procedures immediately when an emergency prevents attendance.
Appearance	Wear clean, appropriate clothing or the approved uniform, display identification when required, and maintain good hygiene.
Communication	Speak respectfully, listen carefully, avoid arguments, and contact the supervisor when guidance is needed.

Expectation	Required Practice
Care plan compliance	Provide only authorized services and follow the current care plan and agency instructions.
Documentation	Record services truthfully, accurately, and promptly. Never document care that was not provided.
Confidentiality	Discuss participant information only with authorized persons and only for legitimate care or business purposes.
Boundaries	Keep the relationship professional. Do not borrow, lend, solicit, pressure, or create personal dependency.
Reporting	Promptly report changes in condition, incidents, safety risks, refusals, suspected mistreatment, and other concerns.

Person-Centered Care

Person-centered care means the participant is treated as an individual whose preferences, routines, culture, goals, abilities, and choices matter. The caregiver supports independence rather than taking control unnecessarily.

- Ask permission before entering private areas or beginning personal care.
- Explain what you are doing and encourage the participant to participate as much as possible.
- Offer choices when choices are available.
- Respect reasonable routines, cultural practices, and preferences.
- Protect modesty and privacy during personal care.
- Report refusals or concerns without threatening, shaming, or forcing the participant.

SCENARIO PRACTICE

What Would You Do?

Scenario 1

You arrive ten minutes late because of traffic. The participant says, “Just write the regular time.”
Correct response: Follow the agency’s timekeeping and late-arrival procedures. Record the actual time and notify the appropriate person. Never falsify time records.

Scenario 2

A participant offers you an expensive bracelet as thanks for helping them.
Correct response: Politely decline and follow the agency gift policy. Report the offer if required.

Scenario 3

A participant refuses a scheduled bath and becomes upset when encouraged.
Correct response: Remain calm, respect the refusal, offer an appropriate alternative if allowed, notify the supervisor as required, and document accurately.

Scenario 4

You notice a new bruise and the participant appears fearful when a relative enters the room.
Correct response: Ensure immediate safety within your role and report the concern promptly according to agency policy. Do not investigate on your own or promise secrecy.

CLASSMARKER ASSESSMENT

After completing Orientation 101, complete the required Hopeful Assurance ClassMarker assessment assigned by the agency. The ClassMarker result is the official testing record for this orientation. Follow agency instructions for completion and submit any required certificate or completion record for the employee training file.

TRAINING RECORD

Attendance and Completion Record

Employee Name _____

Job Title _____

Hire Date _____

Training Date _____

Instructor / Reviewer _____

CLASSMARKER ASSESSMENT RECORD

Complete the agency-assigned ClassMarker assessment after Orientation 101.

Retain the ClassMarker completion record or certificate in the employee training file.

Date Completed: _____ **Score/Result:** _____

Certificate / Reference #: _____

Employee Acknowledgment

I acknowledge that I completed New Hire Orientation 101: Welcome to Hopeful Assurance. I understand the agency mission, values, professional expectations, confidentiality requirements, reporting expectations, and the basic limits of the non-medical caregiver role. I understand that I must follow the current care plan, agency policies, and instructions from authorized supervisors. I know that I should ask my supervisor when I am uncertain about a task or situation.

Employee Signature _____ **Date** _____

Instructor/Supervisor Signature _____ **Date** _____

Administrator Review (if required) _____ **Date** _____

HOPEFUL ASSURANCE UNIVERSITY

New Hire Orientation 102

Policies & Procedures

Hopeful Assurance Home Health Care LLC

OUR STANDARD
Providing Hope. Delivering Assurance. Serving with Compassion.

Employee Name	_____
Position	_____
Date Completed	_____
Instructor	_____

Estimated Completion Time: 30 Minutes

Course Overview

Every employee represents Hopeful Assurance Home Health Care LLC each time they enter a participant's home, communicate with a family, complete documentation, or interact with a coworker. Agency policies help protect participants, employees, and the organization while promoting consistent, safe, and respectful care.

Following agency policies and procedures is a condition of employment. Employees are expected to ask questions whenever instructions are unclear and to report concerns promptly through the proper supervisory channels.

Learning Objectives

- Explain the purpose of agency policies and procedures.
- Demonstrate professional conduct, attendance, and communication expectations.
- Apply documentation, incident-reporting, confidentiality, and social-media rules.
- Maintain safe practices and professional boundaries in participant homes.
- Identify employee responsibilities and when to contact a supervisor.

Orientation Agenda

#	Topic	Time
1	Employee Code of Conduct	4 min
2	Attendance & Dependability	4 min
3	Appearance & Communication	4 min
4	Documentation & Incident Reporting	6 min
5	Confidentiality, Devices & Social Media	5 min
6	Safety, Boundaries & Responsibilities	4 min
7	ClassMarker Assessment & Acknowledgment	3 min

1. Employee Code of Conduct

- Provide services according to the participant's care plan and assigned duties.
- Treat every participant, family member, coworker, and visitor with dignity and respect.
- Be honest, ethical, dependable, and accountable for your actions.
- Protect participant rights, privacy, belongings, and personal choices.
- Report concerns, changes, incidents, and possible violations promptly.
- Never falsify records, misuse participant property, or perform tasks outside your approved role.

HOPEFUL ASSURANCE BEST PRACTICE

Professionalism begins before you enter the home. Your attitude, appearance, punctuality, and communication reflect Hopeful Assurance.

2. Attendance & Dependability

- Report to each assignment on time and remain for the full scheduled service period unless directed otherwise.
- Follow the agency call-in procedure as soon as you know you may be late or absent.
- Do not arrange your own replacement or change a schedule without agency approval.
- Never abandon a participant or leave an assignment without proper notification and authorization.
- Report missed visits, late arrivals, early departures, and schedule conflicts accurately.
- Repeated attendance problems may result in corrective action.

HOPEFUL ASSURANCE BEST PRACTICE

Participants depend on scheduled services. Early communication allows the agency to protect continuity of care.

3. Professional Appearance & Identification

- Wear the approved uniform or clean, appropriate clothing consistent with agency expectations.
- Wear your agency identification badge while providing services.
- Maintain good personal hygiene and a neat appearance.
- Wear closed-toe, non-slip footwear when required for safe care.
- Avoid clothing, jewelry, fragrances, or graphics that are unsafe, distracting, or offensive.
- Keep nails and hair maintained in a manner that supports infection prevention and safe care.

HOPEFUL ASSURANCE BEST PRACTICE

A professional appearance supports trust, safety, and confidence in the services we provide.

4. Professional Communication

- Use calm, courteous, and respectful language.
- Listen carefully and allow participants time to express needs and preferences.
- Avoid arguing, threatening, insulting, gossiping, or discussing personal conflicts in the participant's home.
- Use the proper chain of command when questions or disagreements arise.
- Communicate changes in condition, safety concerns, and service issues promptly.
- Do not make promises on behalf of the agency or provide information outside your authority.

HOPEFUL ASSURANCE BEST PRACTICE

When a conversation becomes difficult, remain calm, protect dignity, and contact your supervisor for guidance.

Scenario Practice

SCENARIO

You are delayed by traffic and will arrive 20 minutes late. The participant is expecting assistance with breakfast. What should you do?

- Notify the agency immediately according to the call-in procedure.
- Do not wait until you arrive to explain the delay.
- Document the actual service time accurately.
- Follow supervisor instructions regarding coverage or schedule changes.

5. Documentation Standards

- Document only services actually provided and observations actually made.
- Complete documentation promptly, accurately, objectively, and in accordance with agency procedures.
- Use clear facts rather than personal opinions, labels, assumptions, or blame.
- Record refusals, changes in condition, safety concerns, and supervisor notifications as required.
- Never chart for another employee or sign another person's name.
- Never alter, erase, backdate, or falsify a record. Follow the approved correction and late-entry procedure.
- Ensure visit times, tasks, signatures, and electronic entries match the services delivered.

REMEMBER

If it was not done, do not document it. If it was not documented, the agency may not be able to verify it.

6. Incident Reporting

- Report participant falls, injuries, suspected abuse, missing persons, medication concerns, property damage, unsafe conditions, and other unusual events immediately.
- Call 911 first when there is an immediate threat to life or safety.
- Notify the supervisor as soon as it is safe to do so.
- Complete required incident documentation within the agency timeframe.
- Document facts, exact observations, actions taken, and notifications made.
- Do not investigate independently, assign blame, or discuss the incident with unauthorized individuals.

REMEMBER

An incident report supports follow-up and quality improvement. It does not replace the regular service note when both are required.

7. Confidentiality & Privacy

- Access participant information only when needed to perform assigned duties.
- Share information only with authorized individuals through approved channels.
- Keep paper records, schedules, electronic devices, and login credentials secure.
- Do not discuss participants in public places, with friends, or with unauthorized family members.
- Protect privacy during personal care, conversations, and documentation.

- Report lost documents, misdirected messages, unauthorized disclosures, or other privacy concerns immediately.

REMEMBER
Use the minimum information necessary to complete your job. When uncertain, ask your supervisor before sharing information.

8. Cell Phones, Texting & Social Media

- Use personal devices during work only as permitted by agency policy and without interfering with participant care.
- Do not photograph, record, livestream, or post a participant, participant home, documents, schedules, or agency information.
- Do not discuss participants or workplace incidents on social media, even without using names.
- Use only agency-approved methods for work-related messages and documentation.
- Do not share passwords or leave devices unlocked where others can access participant information.
- Report a lost or stolen device immediately if it may contain agency or participant information.

REMEMBER
A participant or family member giving verbal permission does not automatically make a photo, recording, or social-media post acceptable.

9. Workplace & Home Safety

- Perform hand hygiene and use required personal protective equipment.
- Follow infection-prevention, emergency, fire, fall-prevention, and safe-body-mechanics procedures.
- Report hazards such as broken equipment, blocked exits, loose rugs, exposed wiring, smoke, gas odors, or unsafe animals.
- Use assistive devices only as trained and assigned.
- Do not perform lifts, transfers, or tasks beyond your training or the care plan.
- Protect yourself and the participant during emergencies; call for help when needed.

HOPEFUL ASSURANCE BEST PRACTICE

Stop and seek assistance when a task cannot be completed safely. Rushing or improvising can injure both the participant and the caregiver.

10. Professional Boundaries

- Do not borrow or lend money, use participant credit cards, or make personal financial arrangements.
- Do not accept large or inappropriate gifts or become involved in participant financial decisions.
- Do not bring unauthorized visitors, children, or pets to an assignment.
- Do not share intimate personal problems or create relationships that interfere with professional judgment.
- Do not purchase, sell, or exchange personal items with participants unless specifically authorized by policy.
- Maintain respectful boundaries in person, by phone, through text, and on social media.

HOPEFUL ASSURANCE BEST PRACTICE

Kindness and compassion are expected. Boundaries protect the participant, the employee, and the professional relationship.

11. Employee Responsibilities

- Review and follow current agency policies, assigned care plans, and supervisor instructions.
- Maintain required credentials, training, health records, and annual competency completion.
- Ask questions before performing unfamiliar or unclear tasks.
- Report changes in participant condition and concerns promptly.
- Cooperate with supervision, quality reviews, investigations, and corrective actions.
- Represent Hopeful Assurance with integrity, compassion, accountability, and respect.

HOPEFUL ASSURANCE BEST PRACTICE

Employees are responsible for knowing where to find policies and for seeking clarification when expectations are unclear.

Key Takeaways

- Follow the care plan, agency policy, and your approved role.
- Be dependable, professional, respectful, and honest.
- Document accurately and report concerns immediately.
- Protect confidentiality in every setting and on every device.
- Maintain safe practices and professional boundaries.
- When unsure, stop and contact your supervisor.

Instructor Guide

- Review the learning objectives and explain that policy compliance is a condition of employment.
- Use examples relevant to the employee's role while avoiding disclosure of participant information.
- Emphasize the call-in procedure, objective documentation, immediate incident reporting, confidentiality, device security, and professional boundaries.
- Allow employees to ask questions and identify where current agency policies are maintained.
- Direct the employee to complete the required ClassMarker assessment after this orientation.
- Document attendance, ClassMarker completion, and the signed acknowledgment in the employee training record.

ClassMarker Assessment Record

After completing Orientation 102, the employee must complete the agency-assigned ClassMarker assessment. The ClassMarker result is the official testing record for this orientation. Retain the completion record or certificate in the employee training file.

Date Completed	_____
Score / Result	_____
Certificate / Reference #	_____

Orientation Attendance Record

Employee Name	Position	Date	Signature

Employee Acknowledgment

I acknowledge that I completed Hopeful Assurance University New Hire Orientation 102 – Policies & Procedures. I understand that I am responsible for following current Hopeful Assurance Home Health Care LLC policies, procedures, care plans, supervisory instructions, confidentiality requirements, safety expectations, and professional standards. I understand that failure to comply may result in corrective action, up to and including termination of employment, consistent with agency policy and applicable law.

Employee Name	_____
Employee Signature	_____
Instructor/Supervisor	_____
Completion Date	_____

Hopeful Assurance Home Health Care LLC

Providing Hope. Delivering Assurance. Serving with Compassion.

EMPLOYEE COMPLIANCE & ACKNOWLEDGMENT FORMS

Hopeful Assurance Home Health Care LLC

Purpose	Forms retained in the employee personnel/training file to document onboarding, policy review, competency, and required acknowledgments.
Applies to	PCS and In-Home Respite direct care workers and other employees as applicable.
Important	Role-specific job descriptions, official Medicaid forms, screening results, and ClassMarker completion records are maintained with these forms.

Hope with Purpose. Care with Compassion.

NEW HIRE PERSONNEL FILE CHECKLIST

Use this checklist to confirm required pre-employment and onboarding items are placed in the employee personnel file. Complete only items applicable to the employee's role.

[ ] Employment application completed and signed

[ ] Government-issued photo identification reviewed

[ ] Form I-9 completed with required work-authorization documentation

[ ] Federal W-4 completed

[ ] Mississippi withholding form completed

[ ] Current driver license verified when driving is a job requirement

[ ] Required fingerprint-based background screening completed

[ ] OIG exclusion check completed

[ ] Mississippi Nurse Aide Abuse Registry check completed, when applicable

[ ] Professional/reference checks completed

[ ] Required credentials/certifications verified

[ ] Current CPR / First Aid documentation, when required by agency or assignment

[ ] HCBS Provider Health Self-Attestation completed before direct service

[ ] Orientation 101 completed and acknowledgment signed

[ ] Orientation 102 completed and acknowledgment signed

[ ] ClassMarker assessment completed; certificate/score report filed

[ ] Role-specific job description reviewed and acknowledgment signed

[ ] Code of Ethics acknowledgment signed

[ ] HIPAA / Confidentiality acknowledgment signed

[ ] Conflict of Interest & Professional Boundaries acknowledgment signed

[ ] Employee Handbook / Policy receipt signed

[ ] Abuse, Neglect & Exploitation / Vulnerable Persons acknowledgment signed

[ ] Attendance / Call-Out / Time-Off policy acknowledgment signed

[ ] Dress Code policy acknowledgment signed

[ ] Holiday policy acknowledgment signed

[ ] Competency / training verification completed

[ ] Qualifying Relative DCW Questionnaire completed, if applicable

Employee Printed Name	Employee Signature	Date
_____	_____	_____
Supervisor/Agency Representative	**Signature**	**Date**
_____	_____	_____

ORIENTATION COMPLETION CHECKLIST

The employee and trainer should verify that the following topics have been reviewed. Orientation 101 and 102 provide the core training content; the ClassMarker assessment is the agency's testing method.

[ ] Agency mission, vision, and core values

[ ] Organizational structure and chain of command

[ ] Role and limits of the non-medical caregiver

[ ] Person-centered care, dignity, choice, privacy, and independence

[ ] Care plan / Plan of Services and Supports compliance

[ ] Attendance, punctuality, call-out, and scheduling expectations

[ ] Professional appearance and identification

[ ] Professional communication and conduct

[ ] Documentation standards and EVV expectations

[ ] Incident reporting and emergency response

[ ] HIPAA, confidentiality, and privacy

[ ] Cell phones, texting, devices, and social media

[ ] Infection prevention / standard precautions

[ ] Home and workplace safety / body mechanics

[ ] Professional boundaries and conflict of interest

[ ] Abuse, neglect, exploitation, fraud, and mandatory reporting

[ ] Complaint and grievance procedures

[ ] Employee handbook and agency policy access

[ ] Role-specific job description

[ ] ClassMarker assessment completion and certificate/score filed

ClassMarker Completion Date: _____ Score/Certificate ID: _____

Employee Printed Name	Employee Signature	Date
_____	_____	_____

Supervisor/Agency Representative	Signature	Date
_____	_____	_____

DIRECT CARE WORKER COMPETENCY & TRAINING VERIFICATION

Mark Competent, Needs Review, or N/A. The evaluator should use observation, demonstration, discussion, or documentation review as appropriate. Do not verify a skill the employee is not authorized or trained to perform.

Skill / Topic	Competent	Needs Review	N/A	Initial/Date
Hand hygiene / standard precautions	[ ]	[ ]	[ ]	_____
PPE use and disposal	[ ]	[ ]	[ ]	_____
Bathing / personal hygiene assistance	[ ]	[ ]	[ ]	_____
Dressing and grooming	[ ]	[ ]	[ ]	_____
Toileting and elimination assistance	[ ]	[ ]	[ ]	_____
Positioning and pressure-injury prevention	[ ]	[ ]	[ ]	_____
Safe transfers within training and care plan	[ ]	[ ]	[ ]	_____
Ambulation / mobility assistance	[ ]	[ ]	[ ]	_____
Meal preparation and nutrition support	[ ]	[ ]	[ ]	_____
Light housekeeping / laundry	[ ]	[ ]	[ ]	_____
Observation and reporting of changes	[ ]	[ ]	[ ]	_____
Accurate service documentation / EVV	[ ]	[ ]	[ ]	_____
Client privacy and confidentiality	[ ]	[ ]	[ ]	_____
Emergency recognition and response	[ ]	[ ]	[ ]	_____
Fall prevention and home safety	[ ]	[ ]	[ ]	_____
Professional communication	[ ]	[ ]	[ ]	_____
Respect for participant rights and property	[ ]	[ ]	[ ]	_____

Additional comments / remediation needed:

_____

_____

_____

Employee Printed Name _____ **Employee Signature** _____ **Date** _____

Evaluator Name/Title _____ **Evaluator Signature** _____ **Date** _____

CODE OF ETHICS ACKNOWLEDGMENT

While working for Hopeful Assurance Home Health Care LLC, I agree to:

[ ] Treat participants, families, coworkers, and visitors with dignity and respect.

[ ] Follow the authorized care plan/PSS, agency policies, and supervisory instructions.

[ ] Provide only services within my role, training, and authorization.

[ ] Maintain truthful time records, EVV entries, and documentation.

[ ] Protect participant privacy, confidentiality, property, and personal choices.

[ ] Maintain professional boundaries; do not borrow/lend money, solicit, or enter personal business arrangements with participants.

[ ] Do not use participant funds, credit cards, accounts, property, or vehicles for personal benefit.

[ ] Do not accept large or inappropriate gifts or tips contrary to agency policy.

[ ] Do not bring unauthorized visitors, children, or pets to assignments.

[ ] Do not consume alcohol, use illegal drugs, or report to work impaired.

[ ] Do not give medical advice, change medications, or perform nursing/medical treatments outside my role.

[ ] Immediately report suspected abuse, neglect, exploitation, fraud, safety concerns, incidents, or significant changes.

[ ] Do not falsify, alter, backdate, or sign another person's records.

[ ] Maintain appropriate communication and avoid discussing participants or agency business with unauthorized persons.

I understand that violations may result in corrective action up to and including termination, consistent with agency policy and applicable law.

Employee Printed Name	Employee Signature	Date
_____	_____	_____

Supervisor/Agency Representative	Signature	Date
_____	_____	_____

HIPAA & CONFIDENTIALITY ACKNOWLEDGMENT

I understand that I may have access to participant, employee, and agency information that is confidential. I agree to protect that information and use or disclose it only for authorized work purposes.

[ ] Access only the minimum information needed to perform assigned duties.

[ ] Discuss participant information only with authorized persons and through approved channels.

[ ] Keep paper records, schedules, electronic devices, passwords, and login credentials secure.

[ ] Never photograph, record, livestream, post, or share participant information or images unless specifically authorized by agency policy and applicable law.

[ ] Do not discuss participants in public places, on social media, or with unauthorized family/friends.

[ ] Immediately report lost documents/devices, misdirected messages, unauthorized disclosures, or suspected privacy breaches.

[ ] Return or securely dispose of confidential information as directed when employment ends.

I understand that confidentiality obligations continue after my employment ends and that violations may result in discipline, termination, and other consequences permitted by law.

Employee Printed Name	Employee Signature	Date
_____	_____	_____
Supervisor/Agency Representative	**Signature**	**Date**
_____	_____	_____

CONFLICT OF INTEREST & PROFESSIONAL BOUNDARIES

I agree to avoid situations in which personal interests interfere with my responsibilities to Hopeful Assurance or the people it serves.

[ ] I will not use confidential participant or agency information for personal gain.

[ ] I will not privately solicit or divert agency participants for personal services.

[ ] I will not accept side payments, loans, or unauthorized gifts from participants or families.

[ ] I will not use participant property, money, accounts, or identifying information for personal purposes.

[ ] I will disclose any actual or potential conflict of interest to the Administrator or Compliance Officer.

[ ] If I am related by blood or marriage to a waiver participant I am assigned to serve, I will immediately notify the agency so required Medicaid eligibility documentation can be completed.

[ ] I will return agency records, property, credentials, and confidential materials upon request or at separation from employment.

Employee Printed Name	Employee Signature	Date
_____	_____	_____

Supervisor/Agency Representative	Signature	Date
_____	_____	_____

EMPLOYEE HANDBOOK / POLICY RECEIPT

I acknowledge that I have received access to the current Hopeful Assurance Home Health Care LLC Employee Handbook and applicable policies and procedures. I understand that I am responsible for reading, understanding, and complying with current agency requirements and asking questions when instructions are unclear.

I understand that agency policies may be revised as operational or regulatory requirements change and that the handbook is not an employment contract.

Employee Printed Name	Employee Signature	Date
_____	_____	_____

Supervisor/Agency Representative	Signature	Date
_____	_____	_____

ABUSE, NEGLECT, EXPLOITATION & VULNERABLE PERSONS ACKNOWLEDGMENT

Hopeful Assurance maintains zero tolerance for abuse, neglect, exploitation, mistreatment, intimidation, harassment, or fraud involving a participant. I understand my duty to protect participants and immediately report suspected or observed concerns through the required agency and regulatory reporting process.

I will not investigate independently, promise secrecy, retaliate against a reporter, or delay an emergency response. When there is an immediate threat to life or safety, I will call emergency services first and then notify the agency as soon as safely possible.

Employee Printed Name	Employee Signature	Date
_____	_____	_____

Supervisor/Agency Representative	Signature	Date
_____	_____	_____

ATTENDANCE, CALL-OUT & TIME-OFF POLICY

Reliable attendance is essential to continuity of care. Employees are expected to report on time and remain for the full authorized service period unless directed otherwise.

[ ] If an emergency prevents attendance, notify the agency/supervisor as soon as possible and, when feasible, at least 2 hours before the scheduled shift.

[ ] For planned appointments or foreseeable absences, provide advance notice according to agency scheduling procedures.

[ ] Time-off requests should normally be submitted at least 2 weeks in advance; approval depends on staffing and participant needs.

[ ] Do not arrange your own replacement or change an assignment without agency approval.

[ ] Do not leave a participant or assignment without proper notification and authorization.

[ ] Accurately report late arrivals, early departures, missed visits, and schedule changes.

[ ] Repeated attendance problems or a no-call/no-show may result in corrective action up to and including termination, consistent with agency policy.

Employee Printed Name	Employee Signature	Date
_____	_____	_____
Supervisor/Agency Representative	**Signature**	**Date**
_____	_____	_____

DRESS CODE & PROFESSIONAL APPEARANCE

Employees must maintain a clean, safe, professional appearance appropriate to home-care services.

[ ] Wear approved scrubs/uniforms in agency colors (pink and burgundy) or other attire specifically approved by the agency.

[ ] Wear the agency identification badge while providing services when required.

[ ] Clothing must be clean, in good condition, and not excessively tight, revealing, or distracting.

[ ] Wear closed-toe, safe footwear suitable for caregiving duties; slip-resistant footwear is recommended when appropriate.

[ ] Maintain good personal hygiene and neat hair/nails in a manner that supports infection prevention and safe care.

[ ] Avoid strong fragrances, unsafe jewelry, offensive graphics, and sleepwear-style head coverings while on duty unless medically/religiously appropriate or specifically approved.

[ ] Follow assignment-specific PPE and infection-control requirements.

Employee Printed Name	Employee Signature	Date
_____	_____	_____
Supervisor/Agency Representative	**Signature**	**Date**
_____	_____	_____

HOLIDAY POLICY ACKNOWLEDGMENT

Hopeful Assurance recognizes the following agency holidays for scheduling purposes:

Holiday	Date
New Year’s Day	January 1
Independence Day	July 4
Thanksgiving Day	Fourth Thursday in November
Christmas Day	December 25

Participant services may still be scheduled on holidays when authorized care is needed. Employees must follow the posted schedule and agency call-out procedures. Holiday pay, if applicable, is governed by the current payroll/employee policy in effect at the time worked.

Employee Printed Name _____ **Employee Signature** _____ **Date** _____

Supervisor/Agency Representative _____ **Signature** _____ **Date** _____

TRAINING VERIFICATION SHEET

Use this page for training completed outside the Orientation 101/102 modules or for documented skills refreshers.

Training Topic	Date	Method / Provider	Employee Initial	Trainer Initial
Hand hygiene / standard precautions				
PPE / infection prevention				
Safe body mechanics / transfers				
Fall prevention / home safety				
Fire safety / evacuation				
Incident reporting				
Abuse / neglect / exploitation reporting				
EVV / documentation				
Meal preparation / food safety				
Other: _____				
Other: _____				

Employee Printed Name _____ **Employee Signature** _____ **Date** _____

Trainer/Supervisor _____ **Signature** _____ **Date** _____

Social MEDIA Waiver FORM

I, _____, grant permission to _____, hereinafter known as the “Media” to use my image (photographs and/or video) for use in Media publications including:

I, _____, deny permission to _____, hereinafter known as the “Media” to use my image (photographs and/or video) for use in Media publications including:

(Check All That Apply)

☐ Videos ☐ Email Blasts ☐ Recruiting Brochures ☐ Newsletters ☐ Magazines ☐ General Publications ☐ Website and/or Affiliates ☐ Other: _____

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please **initial** the paragraph below which is applicable to your present situation:

_____- I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Signature: _____Date: _____

Name (please print): _____

Address: _____

OFFICIAL MEDICAID / AGENCY COMPLIANCE FORMS

Appendix - Complete and retain only when applicable

The following forms are appended in their original format. Do not restyle or alter Medicaid-issued forms. Some forms belong in an employee file; others are for participant records, supervisory visits, incident reporting, or office review.

- HCBS Provider Health Self-Attestation + TB Risk Assessment - direct care employee file
- Notice Regarding Relatives as Direct Care Workers - reference
- Qualifying Relative DCW Questionnaire - complete at hire and annually when applicable
- E&D; Waiver Reportable Incidents Form - use when a reportable incident occurs
- PCS/IHR Supervisory Visit Checklist - supervisor/participant record
- PCS/IHR Office Review Form - agency office compliance / review

Mississippi Division of Medicaid HCBS Provider Health Self-Attestation

In accordance with Mississippi Division of Medicaid's requirement that providers of adult daycare, personal care and in-home respite services are physically/mentally able to provide needed care, all individuals providing direct care will be required to sign the below attestation prior to service provision.

Staff Name: _____ Date of Birth: _____

Provider Agency Name: _____

Hire Date: _____

Please initial the three statements and sign below.

_____ I attest that I have no physical or mental conditions that would prevent me from providing personal care or in home respite services.

_____ I attest that, to my knowledge, I have not been diagnosed with, nor been exposed to coronavirus/COVID-19.

_____ I attest that, to my knowledge, I have not been diagnosed with, nor been exposed to tuberculosis based on the HCP Individual TB Risk Assessment (pg 2 of this form).

_____ _____

Staff Signature Date

Health Care Personnel (HCP)
Baseline Individual TB Risk Assessment

HCP should be considered at increased risk for TB if any of the following statements are marked "Yes":

Temporary or permanent residence of ≥1 month in a country with a high TB rate

Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe

YES ☐ NO ☐

OR

Current or planned immunosuppression,

including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

YES ☐ NO ☐

OR

Close contact with someone who has had infectious TB disease since the last TB test

YES ☐ NO ☐

Abbreviations: HCP, health-care personnel; TB, tuberculosis; TNF, tumor necrosis factor.

Individual risk assessment information can be useful in interpreting TB test results (see Lewinsohn DM, Leonard MK, LoBue PA, et al. Official American Thoracic Society/Infectious Diseases Society of America/Centers for Disease Control and Prevention Clinical Practice Guidelines: Diagnosis of tuberculosis in adults and children. Clin Infec Dis 2017;64:111–5).

Adapted from: Risk assessment form developed by the California Department of Health, Tuberculosis Control Branch.

Sosa LE, Njie GJ, Lobato MN, et al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. MMWR Morb Mortal Wkly Rep 2019;68:439–43. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w

TUBERCULOSIS TESTING + TREATMENT OF U.S. HEALTH CARE PERSONNEL

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention