RIGHT ACCORD
Private Duty-Home Health Care

APPLICANTS

APPLICATION FORMS PART 1

RIGHT ACCORD
Private Duty-Home Health Care
3900 Clark Road Suite B5, Sarasota, FL 34233
941.366.0801 | www.rightaccordhealth.com

Please be aware you will have to have level 2 Background screening done through AHCA

- Social Security card/passport
- Driver's License
- Green Card (**if permanent resident**)
- CPR (valid) certificate
- HHA/CAN card with License # (valid)
- Auto Insurance
- Fit to work Letter From your Doctor (**must be in the last six months**)
- HIV/AIDS training certificate
- Alzheimer training certificate

  (**optional on day of but must produce in 10 days**)
- Assistant with Medication certificate

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Applicant Questionnaire

APPLICANT NAME: _____ **DATE**: _____

MOBILE PHONE: _____ **EMAIL**: _____

The following questions are pertinent to certifications/licenses required to be working as a CNA / HHA. Please answer each question. You will also need to attach an up to date resume with this questionnaire in order to be considered for an interview with our Human Resources department.

#	Question	Response YES OR NO
1.	Are you a Florida CNA license? Provide expiration date. Do you have AHCA Criminal Background checks?	- -
2.	Are you a HHA? Provide date received and where you received the certification from.	-
3.	Do you have up-to-date CPR certification? Provide expiration date	-
4.	Do you have Medication Assistance Certification? Provide date.	-
5.	Do you have HIV/AIDS Certification? Provide date.	-
6.	Do you have Alzheimer's Certification? Provide date.	-
7.	Are you legally authorized to work in the U.S.?	-
8.	Have you ever been convicted of a crime? Do you require Disability Accommodation?	-
9.	Have you undergone the state mandated Level II Background Screening? **Please Note: As mandated in the state of Florida, those working in Home Health Agencies must be 'eligible' to work according to the Level II Background Screening results.	-
10.	Do you have an up-to-date health statement? Provide date obtained.	-

	Are you currently under medical treatment?	-
11.	This job may require you to run errands by automobile. Do you have a valid driver's license, insurance up to date and access to an automobile?	-
12.	What is your availability? Please be specific in days and times.	-
14.	Are you currently working for any other agencies and if so what are your consistent shifts?	-

Please provide one ***professional*** references below:

Name	Title	Phone
Company	Company Address	

By signing below, I certify that the information contained in this questionnaire is true and complete. I understand that false information may be grounds for not hiring me or for immediate termination of employment at any point in the future if I am hired. I authorize the verification of any or all information listed above.

Applicant Signature Date

Office Use ONLY		
Interviewed By:	Date:	Time:

UPDATED JANUARY 2020

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BACKGROUND SCREENING

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

1-789 (08-11-2010)

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATMENT

Authority: The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92 -544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94 -29; Pub. L. 101 -604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI 009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information: Th e requesting agency and/ or the agency con ducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____
Employee Name (Printed)

_____
Employee Signature

_____
Date

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DRUG TESTING AUTHORIZATION & CONSENT FORM
SMART SCREENS

I, the undersigned, hereby knowingly and voluntarily authorize and consent to the collection and testing of specimens of my urine by a collection site, laboratory, and medical review officer (MRO) using the Smart Screens testing technology and services for the purpose of drug testing and data collection.

I authorize the individual performing the collection, collection site, laboratory, MRO, and Smart Screens to receive and disclose the results of my drug tests to the company that has requested I undergo drug testing.

I acknowledge that the drug test results may be utilized by the company that has requested I undergo drug testing to determine my eligibility for employment or continued employment, therewith, for insurance coverage determinations, or for any other reason that has been disclosed to me by such entity.

I acknowledge that at the time of collection, a refusal to authorize the collection and testing of my urine by the individual performing the collection, collection site, laboratory, or MRO, or a refusal to authorize the above disclosure of the test results will be treated as a positive drug test and that the same shall be reported to the requesting company. I further acknowledge that a positive drug test may result in disciplinary action up to and including denial of employment or termination, if hired, a denial of insurance coverage, or any other negative repercussions that may arise related to the purpose of the testing.

I acknowledge that the collection and testing of specimens of my urine shall be facilitated using Smart Screens' state-of the- art hardware and software. I acknowledge that Smart Screens shall collect, process, and disclose my personal information, including the results of my drug test, in accordance with the Smart Screens Privacy Policy. This may include the provision of such information to my employer, potential employer, or a governmental agency involved in a legal proceeding or investigation connected with the test.

I further acknowledge and agree that while Smart Screens will only report to the requesting company the results of those tests specifically requested thereby, Smart Screens may also collect and test specimens of my urine for purposes unrelated to the initial request and may keep and compile such results into de-identified aggregate statistics or otherwise use and disclose the same for any purpose whatsoever (including commercial purposes) so long as such results are de-identified. In such an event, I shall not be authorized to receive a copy or notice of test purposes or results.

In addition, I hereby knowingly and voluntarily release and hold harmless the company that has requested I undergo drug testing, Smart Screens, the individual performing the collection, the collection site, the testing laboratory, MRO, and their respective officers, directors, employees, and agents from any and all claims, damages, losses, liabilities, costs, and expenses, including attorneys' fees, arising from or relating to such collection and testing and any disclosure of the results thereof, including without limitation, the disclosure of any inaccurate or incomplete results, to the fullest extent permitted by law. This means that I will not sue or hold responsible such parties for any alleged harm to me that might result from the disclose of my test results of private information or from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug test or denial of insurance coverage, even if an error is made in the collection, administration, or analysis of the test or the reporting of the results.

I acknowledge that I have the right to receive a copy of this Drug Testing Authorization & Consent Form. I have read and understand the above Drug Testing Authorization & Consent Form in its entirety, and I agree that a copy of this document is as valid as the original. I have been told that if I have any questions about the test or the policy, they will be answered.

APPLICANT / EMPLOYEE:

Print Name: _____ SS #:_____

Signature: _____ Date:_____

WITNESS:

Print Name: _____

Signature: _____

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

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APPLICATION

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APPLICATION FOR EMPLOYMENT

We are an equal opportunity employer, dedicated to a policy of non- discrimination in employment on any basis including race, color, age, sex, religion, disability, medical condition, national origin, or marital status.

Basic Information		
Name		Date
Street Address		
City	State	Zip
Phone	Email	
I am applying for a position as a		
Have you ever been convicted to a felony? ☐ Yes ☐ No		
If yes, please provide details		
Emergency Contact		
Name	Phone	
Address	Relationship	
Transportation		
Many caregiver positions require the caregiver to transport the client.		
Driver License Number:	Do you have dependable transportation? ☐ Yes ☐ No	
Are you willing to transport a client in your car? ☐ Yes ☐ No	Are you willing to transport client in their car? ☐ Yes ☐ No	Do you have a clean driving record? ☐ Yes ☐ No
Do you have auto insurance? ☐ Yes ☐ No	How many miles are you willing to travel to an assignment?	

Availability (Please specify your availability)						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
☐	☐	☐	☐	☐	☐	☐

Number of hour you would like to work:	Can you be called at the last minute to fill in a shift?	Can you work overnight shifts?	Can you work live-in shifts?
	-	-	-

Additional Comments:

Education		
High School	City/State	Dates
College	City/State	Dates
Other	City/State	Dates
Degree/Certificates		
Special Skills or Courses		

Experience
Discuss any training or experiences working with elderly.
What would you like most about working with the elderly?
What would you like least about working with the elderly?

Skills
Please indicate whether you have assisted with or performed the following tasks for seniors.

Shower Client	☐ Yes	☐ No	**Wheel Chair/ Walker**	☐ Yes	☐ No	**Light Housekeeping**	☐ Yes	☐ No
Bathing/ Dressing	☐ Yes	☐ No	**Hoyer Lift**	☐ Yes	☐ No	**Grocery Shopping**	☐ Yes	☐ No
Grooming	☐ Yes	☐ No	**Gait Belt**	☐ Yes	☐ No	**Cooking**	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No	**ROM**	☐ Yes	☐ No	**Driving**	☐ Yes	☐ No
Transfer Assist	☐ Yes	☐ No	**Urinal/Bedpan**	☐ Yes	☐ No	**Medication Reminders**	☐ Yes	☐ No

Please indicate if you have had experience with the following:

Alzheimer's Dementia	☐ Yes	☐ No	Assisted Living Facilities	☐ Yes ☐ No
Diabetes	☐ Yes	☐ No	Long Term Care Facilities	☐ Yes ☐ No
Oncology	☐ Yes	☐ No	Rehabilitation Facilities	☐ Yes ☐ No
Parkinson's	☐ Yes	☐ No	Hospice	☐ Yes ☐ No
Mentally Handicapped	☐ Yes	☐ No	Hospitals	☐ Yes ☐ No
HIV/Aids	☐ Yes	☐ No	Private Home	☐ Yes ☐ No
Pediatric	☐ Yes	☐ No	Retirement Facilities	☐ Yes ☐ No

Preferences
Check off items that pertain to you. Add any additional comments in the space below.

☐	No Alzheimer's Clients	☐	No Housekeeping
☐	No Cats/Dogs	☐	No Transporting Clients
☐	No Hospice Clients	☐	No Cooking
☐	No Lifting	☐	No Transfers
☐	No Smoking	☐	No Couples
☐	No Men Clients	☐	No Women Clients
☐	No Clients in Facilities	☐	No Total Care Clients

Employment History Please go back at least five years and tell us about your work history. Use reverse side of sheet if additional space required.		
May we contact your current employee?		
Company	From	To
Job Title	Reason Left	
Duties		
Supervisor	Phone	
Company	From	To
Job Title	Reason Left	
Duties		
Supervisor	Phone	
Company	From	To
Job Title	Reason Left	
Duties		
Supervisor	Phone	
Company	From	To
Job Title	Reason Left	
Duties		
Supervisor	Phone	

Business References			
Name	Address	Relationship	Local Phone #
Name	Address	Relationship	Local Phone #
Name	Address	Relationship	Local Phone #
Name	Address	Relationship	Local Phone #
Name	Address	Relationship	Local Phone #

Personal References			
Name	Address	Relationship/Years Known	Local Phone #
Name	Address	Relationship/Years Known	Local Phone #
Name	Address	Relationship/Years Known	Local Phone #
Name	Address	Relationship/Years Known	Local Phone #
Name	Address	Relationship/Years Known	Local Phone #

CERTICATION AND RELEASE: I certify that I have read and understand the application note on page one of this form and that the answers given by me to the foregoing questions and the statements made by me are complete and true the best of my to the foregoing questions and the statements made by me are complete and true to the best of my knowledge and belief. I understand that any false information, omissions, or misrepresentation of facts called for in this application may result in rejection of my application or discharge at any time during my employment. I authorize the company and/or its agents, including consumer reporting bureaus, to verify any information including, but not limited to, criminal history and motor vehicle driving records. I authorize all persons, schools, companies and law enforcement authorities to release any information concerning my background and hereby release any said persons, schools, companies, and law enforcement authorities from any liability for any damage whatsoever for issuing this information. I also understand that the use of illegal drugs is prohibited during employment. If company policy requires, I am willing to submit to drug testing to detect the use of illegal drugs prior to and during employment.	
Print Name	Date
Signature	Date

For Office Use Only – Interview Comments

RIGHT ACCORD
Private Duty-Home Health Care

COMPETENCY TEST

RIGHT ACCORD
Private Duty-Home Health Care

HOME HEALTH AIDE COMPETENCY TEST

Name:_____

Date:_____

AHCA Form # 3110-1007, February 2001

Home Health Aide Competency Test
Written Examination

I. ROLE OF THE HOME HEALTH AIDE

An aide may perform certain duties. Mark the following true or false for tasks you may legally perform as a home health aide. T=True F=False

_____1. Reinforce a dressing.
_____2. Apply a hot pack.
_____3. Give an enema.
_____4. Administer medication.
_____5. Change a sterile dressing.
_____6. Assist with change of a colostomy bag.
_____7. Give a rectal suppository.
_____8. Give a tubal feeding.
_____9. Give insulin.
____10. Cut Nails.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

11. As a home health aide, you:

A. work alone.
B. work as part of the health care team.
C. may become the leader of the health care team.
D. will never get any further training after orientation.

12. When you work in the home, you will be:

A. responsible for making decisions without any help.
B. working under the supervision of a professional supervisor.
C. away from your office and have no way to contact your employer.
D. responsible for calling the physician with information.

13. As home health aide, it is your responsibility to:

A. plan the client's care.
B. do only the tasks that the registered nurse or therapist assigns to you.
C. try to do your best, but not ask for any help.
D. compare assignments with your co-workers.

II. COMMUNICATION

Mark the following true or false. T=True F=False

_____14. In the home, it is important to be a good listener.
_____15. Always tell the patient what you are going to do before starting a procedure.
_____16. You only communicate through words.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

17. Which of the following is important in communicating with people:

A. courtesy.
B. tact.
C. listening.
D. all of the above.

18. Body language is:

A. a way of communicating feelings by using the body, facial expressions and the eyes.
B. only used by clients to tell their doctors what is causing them problems.
C. only used by persons who are deaf and mute.
D. the newest dance craze.

19. Aide care for a conscious patient should be preceded by:

A. asking the patient for his permission to go ahead with the procedure.
B. telling the patient you would like to have his cooperation.
C. giving an explanation of what is going to be done.
D. explanation to the patient that the doctor ordered this done.

20. Miss Ferris, a home health aide, is assigned to care for Mr. Conway. Miss Ferris notices that she feels very angry when she is with Mr. Conway. What should Miss Ferris do because she feels this way?

A. Tell Mr. Conway how she is feeling.
B. Find out if other aides have felt this way.
C. Try to pretend that Mr. Conway is someone she likes.
D. Talk with the agency supervisor about the situation.

21. A patient accuses a home health aide of stealing five dollars. The aide has not taken the patient's money, but the patient does not believe this. What should the aide do?

- A. Ask the other aides who care for the patient if they took the five dollars.
- B. Ask the patient why the aide is being accused.
- C. Offer to give the patient five dollars.
- D. Notify the agency supervisor.

III. OBSERVATION, REPORTING AND DOCUMENTATION

Mark the following true or false. T=True F=False

_____22. If you do not chart a task that you do for a patient, legally, it was not done.
_____23. If the patient has a new area of skin breakdown, and the nurse is coming in two days, you do not need to report the skin breakdown to your supervisor.
_____24. A rapid pulse and shortness of breath in a patient usually indicates the patient is excited and does not need to be reported to the nurse.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

25. The patient tells you he has not moved his bowels in three days. What should you do?

- A. Tell him not to worry about it.
- B. Tell him to take a laxative.
- C. Report it to the nursing supervisor.
- D. Pretend you didn't hear him.

26. Which of these actions is the home health aide permitted to take in relation to drug administration?

- A. Recording and reporting the patient's reaction to the medication.
- B. Handing out nonprescription medications to the patient who asks for them.
- C. Adjusting the dosage of medications given to the patient.
- D. Adjusting the times medications are given to fit into the patient's activities schedule.

27. When a patient complains of pain, what should the home health aide do first?

- A. Ask the patient to describe the pain.
- B. Call the patient's doctor.
- C. Offer the patient some warm tea.
- D. Change the patient's position.

28. A patient's prescription for heart pills has recently been changed. The home health aide should notify the agency supervisor immediately if the patient makes which of these comments?

- A. "The pills are very expensive."
- B. "These pills are different shape from the pills I used to take."
- C. "I have a rash on my stomach since I've been taking these pills."
- D. "I can't take these pills unless I have really cold water to drink."

29. Mrs. Rand, who has diabetes and takes insulin regularly, tells the home health aide that she feels very nervous and jittery. What should the aide do immediately?

- A. Take her temperature.
- B. Find out when she has her next doctor's appointment.
- C. Have her lie down in bed.
- D. Give her a glass of orange juice.

IV. READING AND RECORDING TEMPERATURE, PULSE AND RESPIRATIONS

Mark the following true or false. T=True F=False

_____30. Always report a pulse rate if the beats per minute are under 60 or over 100.
_____31. The temperature of an unconscious patient should be taken orally since they are not moving about.
_____32. Recording a patient's "TPR" or vital signs is not important as long as you remember what they were.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

33. For which, if any, of these body areas is 99.6 degrees F. a normal temperature?

- A. Axilla.
- B. Mouth.
- C. Rectum.
- D. None of the above.

34. When taking a patient's pulse, you should take it for:

- A. 15 seconds.
- B. one full minute.
- C. 5 seconds.
- D. two minutes.

35. When a patient's respirations are being counted, it is best that the patient:

- A. tries to breath evenly.
- B. tries to breathe as deeply as he can.
- C. sits up straight.
- D. not be aware that the respirations are being counted.

V. INFECTION CONTROL

Mark the following true or false. T=True F=False.

_____36. Hand washing is the single best way to decrease the transfer of pathogens.
_____37. Gloves should be worn when handling items soiled by body fluids.
_____38. The catheter drainage bag must be lower than the bladder, but not on the floor.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

39. During a visit, you need to wash your hands after removing gloves:

- A. before you give physical care to the patient.
- B. after you pet the dog.
- C. before you leave the patient's home.
- D. all of the above.

40. In what situation should gloves be used?

- A. The patient is vomiting.
- B. The patient has been incontinent of stool.
- C. The patient has drainage wound.
- D. All of the above.

VI. BODY FUNCTIONS AND CHANGES

Mark the following true or false. T=True F=False

_____41. Diarrhea can cause dehydration and other serious complications and should be reported.
_____42. If a person complains of pain, it is important to have the patient describe the pain and then report it to the nurse and record it in your notes.
_____43. It's normal for most people to complain of pressure, swelling, or bloating in their ankles, feet, stomach or legs.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER

44. If you notice the patient's catheter is not draining, the first thing you should do is:

A. call your supervisor.
B. empty the drainage bag.
C. check the tubing to see if it is kinked.
D. do nothing, this is the nurse's problem.

45. Which of the following is not recommended for promoting good daily bowel habits:

A. plenty of water.
B. laxatives.
C. exercise.
D. well balanced meals.

46. The patient's pulse has been between 90 and 110 beats per minute since his first aide visit. Now you find it to be 58 beats per minute. What should you do next?

A. Tell the patient he must be getting better.
B. Wait 15 minutes and take the pulse again.
C. Inform the supervisor right away.
D. Just record the pulse in the normal way.

47. Mrs. Amos has not had a bowel movement for three days. She has always given herself an enema if she does not have a bowel movement for that long a time. Mrs. Amos asks the home health aide to give her an enema. What should the aide do?

A. Give Mrs. Amos an enema.
B. Tell Mrs. Amos to wait another day.
C. Suggest that Mrs. Amos take a laxative first.
D. Contact the agency supervisor to discuss the situation.

VII. MAINTAINANCE OF A CLEAN, SAFE ENVIRONMENT

Mark the following true or false. T=True F=False

_____48. A bedside call bell needs to be available so the bed bound patient can summon assistance.
_____49. Bedrails should never be used to secure vest restraints.
_____50. Smoking in bed is fine for anyone who is not confused.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER

51. Part of your duties as a home health aide are to assure safe home environment. This includes:

A. proper infection control with good hand washing.
B. electrical and fire safety.
C. moving things which may cause the patient to fall.
D. all of the above.

52. A patient is receiving oxygen through a nasal cannula. What safety precautions should the home health aide take?

A. Keep the television set at least 5 feet from the oxygen tank.
B. Do not permit the patient to drink soda.
C. Allow no smoking in the patient's room.
D. Do not use any lotions that contain oil in the patient's room.

VIII. EMERGENCY PROCEDURES

Mark the following true or false. T=True F=False

_____53. For an injury with profuse bleeding, apply pressure and call for assistance.
_____54. If the patient begins to have a seizure, your first responsibility is to prevent the patient from injuring himself.
_____55. If the patient falls and complains of pain in his hip, you should help him to get up and walk to the bed.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

56. A patient is choking on some object that is caught in his airway. Before first-aid measures are applied, find out:

A. if the patient's pulse rate is over 80.
B. if the patient can swallow clear fluids.
C. if the patient can speak or cough.
D. What medications the patient has taken in the past 24 hours.

57. While giving a bath on a shower chair, the patient suddenly gasps and becomes unresponsive. The home health aide should:

A. call for family assistance and continue with the bath.
B. leave the patient and call 911.
C. lower the patient to the floor, call for the family to call 911, determine if CPR is needed and initiate it if indicated.
D. tell the family to stay with the patient while you call 911 and the supervisor.

58. For which of these emergencies is a knowledge of pressure points essential?

A. Health stroke.
B. Burns.
C. Food poisoning.
D. Bleeding.

59. The telephone numbers of all of the following are important to a patient. Which number must the home health aide have next to the telephone?

A. The patient's clergyman.
B. The drugstore.
C. The emergency medical squad.
D. The next-door neighbor.

IX. HUMAN DEVELOPMENT

Mark the following true or false. T=True F=False

_____60. Every patient is the same and has the same needs and wants.
_____61. It is all right to use any item in the home without asking as long as it is for the patient's personal care.
_____62. You may use the telephone in the patient's home without asking permission.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

63. A neighbor has asked you some questions about the patient you are presently taking care of. "Mrs. Collier is dying, isn't she?" How will you answer her?

A. "Mrs. Collier is doing as well as can be expected."
B. "I am sorry, but I cannot discuss Mrs. Collier."
C. "Yes, it's too bad, but she's very ill."
D. "How did you know about Mrs. Collier and her illness?"

64. Which of these statements about the elderly is true?

- A. They cannot change.
- B. They can learn new things.
- C. They want to become dependent on others.
- D. They do not enjoy meeting new people.

65. When working with person who are disabled, the general goal of care is to:

- A. provide constant supervision.
- B. provide total care.
- C. promote maximum self-care and independence within the limits of the person's ability.
- D. promote the complete return of the person's abilities.

66. It is Mrs. Amos's usual time for lunch, but she says she is not hungry yet. This is the first time that Mrs. Amos has made this type of statement. What should the home health aide do?

- A. Insist that Mrs. Amos eat at this time.
- B. Tell Mrs. Amos to let the aide know when she wants to eat, and remind her that it is important that she have lunch.
- C. Tell Mrs. Amos that if she does not eat by herself, she will have to be fed.
- D. Tell Mrs. Amos that it took a lot to time to prepare the food and that she should eat it while it is fresh.

67. The ability to make observations is even more important when working with infants and young children than it is when working with adults. The chief reason for this is that infants and young children:

- A. do not like to be told what to do.
- B. are usually sicker than adults.
- C. enjoy human contact more than adults.
- D. cannot explain how they feel.

X. PERSONAL CARE

Mark the following true or false. T=True F=False

_____68. It is important to keep a patient covered during a bedbath except for the part being washed.

_____69. Massaging of bony prominences helps to prevent skin breakdown by increasing the blood supply to the area.

_____70. When giving peri-care to a patient after a BM, wash using a front to back motion in order not to spread fecal material to other areas.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

71. Which of the following is most appropriate practice to promote good skin care in the elderly:

A. keep the skin clean and well moisturized.
B. apply alcohol to bare areas of the skin.
C. wash daily with scented soaps.
D. all of the above.

72. If dentures are not worn when sleeping, where should you store them?

A. Wrap in a washcloth.
B. Put in a sterile container.
C. Wrap in a guaze pad.
D. Place in a clean container in clean water.

73. Why is it important that a patient have good mouth care?

A. Bacteria in the mouth can cause tooth decay and gum infections.
B. The saliva in the mouth is the source of stomach juices.
C. Poor oral hygiene causes more saliva to be made.
D. Poor oral hygiene interferes with the sense of smell.

74. An elderly male patient occasionally wets his trousers. What should the home health aide do?

A. Give him fluids with his meals only.
B. Avoid giving his coffee and tea.
C. Tell him if he urinates on himself he will have to be put in diapers.
D. Encourage him to go to the bathroom at least every two hours.

75. In giving foot care to a patient who has diabetes, the home health aide may take which of these actions?

A. Clean under the toenails.
B. Cut the toenails.
C. Soak the patient's feet for more than 5 minutes in a basin of warm water.
D. Put lotion on the patient's feet after drying them.

XI. SAFE TRANSFER TECHNIQUES AND AMBULATION

Mark the following true or false. T=True F=False

_____76. Always transfer a patient towards his good side.
_____77. There is no need to be near an object to pick it up, just reach.
_____78. It's best to use a gait belt if a patient is unsteady.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

79. A patient lying on his back has slid down in bed and needs help in moving up again. To start this, the patient should, if possible:

A. raise himself on his elbows.
B. separate his legs widely.
C. arch his back.
D. flex his knees and push with his heels.

80. Before helping a patient into or out of a wheelchair, which of these actions are necessary?

A. Have the brakes unlocked and leave the foot pieces down.
B. Lock the brakes and fold the foot pieces up.
C. Have the brake unlocked and the foot pieces up.
D. Lock the brakes and leave the foot pieces down.

81. When assisting a patient to walk with his walker, you should:

A. clear a pathway and remove all safety hazards.
B. stay close to the patient's side.
C. stand on the other side of the room.
D. A and B.

82. A patient who has been on bed rest is to get up in a chair. The home health aide helps the patient to sit on the edge of the bed. The patient says, "I am dizzy." What should the aide do?

A. Rub the patient's feet.
B. Help the patient to a standing position and see if the dizziness goes away.
C. Put a cool compress on the patient's head.
D. Support the patient in a sitting position and wait a minute or so to see if the dizziness goes away.

83. Patient has had a stroke and has a right-sided weakness. The patient can walk with a little assistance. It is best for the home health aide to assist the patient by walking in which of these positions?

- A. Directly in front of the patient.
- B. Directly in back of the patient.
- C. On the patient's left side.
- D. On the patient's right side.

84. Mr. Stone is 76 years old, needs help with bathing, and has a foley catheter in place. He has great difficulty walking and uses a wheelchair. When helping Mr. Stone from the bed to the wheelchair, which of these actions is <u>essential</u>.

- A. Place the foot supports of the wheelchair so that he can step up on them.
- B. Have a blanket draped in the wheelchair.
- C. Have the brakes on the wheelchair in a locked position.
- D. Place a pillow on the seat of the wheelchair.

XII. <u>NORMAL RANGE OF MOTION</u>

Mark the following true or false. T=True F=False

_____85. Passive range of motion exercises are for the prevention of contractures in patients with paralyzed limbs.

_____86. During range of motion exercises, if you feel resistance or the patient complains of pain, you should continue anyway.

_____87. It's best to have a pillow between the legs of a patient with a new hip replacement.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

88. To prevent bedsores in the elderly, you should:

- A. change the patient's position every two hours if they are unable to do so themselves.
- B. get the patient out of bed if they are allowed to do so.
- C. ensure adequate nutrition with special emphasis on protein intake.
- D. all of the above.

89. The home health aide should be sure to take which of these actions when caring for a newborn baby?

- A. Support the baby's head and neck when picking the baby up.
- B. Clean the inside of the baby's ears with cotton swabs.
- C. Use petroleum jelly to keep the area around the baby's naval moist.
- D. Hold the baby only at feeding and bathing times.

90. Which of these statements describes good body mechanics?

- A. Carry heavy objects as far away from the body as possible.
- B. Bend the knees when lifting an object off the floor.
- C. Bend over at the waist when lifting an object from the floor.
- D. Lift rather than push a heavy object.

91. When caring for a patient who is on bed rest, what should the aide do to prevent bedsores?

- A. Keep the top sheets well tucked in.
- B. Keep the bottom sheet free of wrinkles.
- C. Use only sheets that are 100% cotton on the patient's bed.
- D. Use only woolen blankets to cover the patient.

92. Physical therapy has started range of motion exercise. Which of these statements about exercise is true?

- A. If a patient cannot talk, do not explain the exercises to the patient.
- B. During exercise, all joints should be moved in all directions.
- C. When the patient does not assist when the joint is moved through its range of motion, the exercise is called active exercise.
- D. It is important to support the body parts above and below the joints when they are moved during exercises.

XIII. NUTRITION

Mark the following true or false. T=True F=False

_____93. Soy sauce is good to spice up a low salt diet.
_____94. A regular diet is a well balanced diet with no restrictions.
_____95. Bread and potatoes are a good source of protein.

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

96. Foods on a liquid diet would include:

A. chicken, eggs and toast.
B. chopped and strained foods.
C. broth, tea and jello.
D. lightly seasoned foods.

97. Foods that are high in vitamin C include:

A. oranges, tomatoes and watermelon.
B. potatoes, raisins and bananas.
C. liver, beef and chicken.
D, cheese, milk and cottage cheese.

98. If there is 50cc left in glass and the glass holds 150cc you should record the intake as:

A. 90cc.
B. 120cc.
C. 100cc.
D. 50cc.

99. Which of these fluids if highest in protein?

A. Vegetable broth.
B. Lemonade.
C. Tomato juice.
D. Eggnog.

100. Milk is a good source of calcium. Which of these foods is also high in calcium?

A. Cheese.
B. Bananas.
C. Orange juice.
D. Raisins.

101. When patients do not have enough fluids, they may develop which of these problems?

A. Diarrhea.
B. Swelling.
C. Constipation.
D. Dandruff

102. If a patient is to have a fluid intake record kept, the right time to record the patient's fluid is:

- A. when the fluids are served to the patient.
- B. when the patient has drank the fluids.
- C. every 2 hours.
- D.
- E. after each meal.

103. Patient on low salt diets are usually allowed to have which of these foods?

- A. Hard cheeses.
- B. Canned soups.
- C. Raisins.
- D. Olives.

XIV. CULTURAL DIFFERNCES IN FAMILIES

CHOOSE ONE CORRECT ANSWER FOR EACH QUESTION BELOW AND CIRCLE THE CORRESPONDING LETTER.

104. Patients sometimes express religious beliefs with which the home health aide does not agree. In dealing with these situations, which of these understandings should the aide use as a guide?

- A. Patients have a right to their own beliefs, which should be respected.
- B. Patients should be told not to discuss their beliefs with aides.
- C. Aides should explain their beliefs to patients.
- D. Aides should pretend to have the same beliefs that patients have.