Trusted Homecare Services
A Homecare Company You Can Trust

INDEPENDENT CONTRACTOR PACKAGE

Name: ______________________________________ Start Date:___________

Scrub Size: Position Interested In:

ACHA Background Screening Date: Expiration Date:

AHCA Fingerprint Screening Date: Expiration Date:

HHA # of Hours or
CNA Expiration Date
Work Authorization Type:
Expiration:

HHA or CNA Certificate Photo

TYPE	EXPIRATION DATE	PHOTO UPLOADS
Professional Liability		
Insurance Auto Insurance		
Driver's License		
Social Security Card		
Physician's Statement Date:	**Expiration Date:**	
CPR Card		
County License (if in Palm		
Beach) HIV/AIDS Training		
OSHA Training		
Domestic Violence		
Vaccines		

- ☐ **Assisting with Self Administration of Medication Training** (2hrs minimum)
- ☐ **Yearly CEU's**
  Number of hours for current year: ______________________

Last Updated: Jan 2022

Trusted Homecare Services
A Homecare Company You Can Trust

APPLICATION

First: M/I Last:	Social Security # ---------------- _____
Address:	Date of Birth: _____/____ /______
City: State: Zip: Phone #:	

DESIRED POSITION

Position:	Date you can Start:
Are you currently Employed:	If Employed, May we Inquire of your current Employer:
Have you Applied to This Company Before:	If so, where and when:

EDUCATION

High School	Name & Location of School	
	Years Attended Completed (Diploma/Degree)	Year Graduated:
University/College Undergraduate/Graduate	Name & Location of School	
	Years Attended Completed (Diploma/Degree)	Year Graduated:
Trade, Business or Correspondence School	Name & Location of School	
	Years Attended Completed (Diploma/Degree)	Year Graduated:

EMPLOYMENT HISTORY

Employer:		Job Title:
Address:		Duties:
Phone:		Salary:
Date From:	Date to:	Reason for Leaving:
Employer:		Job Title:
Address:		Duties:
Phone:		Salary:
Date From:	Date to:	Reason for Leaving:
Employer:		Job Title:
Address:		Duties:
Phone:		Salary:
Date From:	Date to:	Reason for Leaving:

PROFESSIONAL REFERENCES

Name	Occupation
Address:	Relationship:
	Years Known:
Phone:	
Name	Occupation
Address:	Relationship:
	Years Known:
Phone:	
Name	Occupation
Address:	Relationship:
	Years Known:
Phone:	

PHYSICAL RECORD

Do you have any disabilities that prevent you from performing the work for which you are applying: If so, describe:	
Have you ever been injured?	Provide Details:
In Case of emergency notify:	: Phone:

ADDITIONAL AREAS OF EXPERTISE

Areas of specialized study; research or additional experience:	
List the foreign languages you speak fluently:	
U.S. Military Service: Rank:	Present membership in National Guard or Reserves:
Have you ever been in the U.S. Armed Forces?	What is your present selective services classification:
Are you presently a member of Reserves or National Guard?	If so, when is your enlistment up?

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to a Referral Independent Contractor Agreement, I understand that false or misleading information in my application or interview may result in the Referral Independent Contractor Agreement being terminated.

Signature:____________________________ **Date:** ________________________

AUTHORIZATON TO RELEASE INFORMATION

I voluntarily give TRUSTED HOMECARE SERVICES the right to make a thorough investigation of my past employment and activities and agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I consent to take the pre-assignment physical examination, and such future physical examinations as be required by TRUSTED HOMECARE SERVICES at such times they designate.

I understand that I will be required to follow the policies and rules of TRUSTED HOMECARE SERVICES and any infractions of said rules may lead to termination of my Referral Independent Contractor Agreement. I also understand that my Referral Independent Contractor Agreement may be terminated for any misstatement or omission of fact appearing in this application form.

______________________ ______________________________

Date Applicant's Signature

AVAILABILITY RECORD

Primary position desired ________________________

Will you accept another position?____Yes____No

If so, what?___________________________________

Are you available to work: Weekends?_____Yes_____No

Holidays?______Yes____No

Rotating Shift Yes No

Please Indicate Days and Hours You Are Available to Work (Be Specific)

	Start:	End:
Sunday	AM	AM
	PM	PM
Monday	AM	AM
	PM	PM
Tuesday	AM	AM
	PM	PM
Wednesday	AM	AM
	PM	PM
Thursday	AM	AM
	PM	PM
Friday	AM	AM
	PM	PM
Saturday	AM	AM
	PM	PM

Do you have responsibilities that would limit your availability?

___**Yes**______**No** If yes, explain_______

____

CERTIFIED NURSING ASSISTANT (CNA) / HOME HEALTH AIDE (HHA)

JOB DESCRIPTION

CNAs and HHAs referred by Nurse Registries must provide evidence of a home health aide training course of at least 40 hours in compliance with Rule 59A-18.0081, F.A.C., Section 400.506 (6), F.S., or certification from the Florida Board of Nursing, Department of Health as a certified nursing assistant; proof of completion of a one-time HIV/AIDS training course and (2) hours minimum training on assisting with self-administration of medication as described in Section 400.488, F.S.; evidence of background screening that meets the requirements in Section 408.809(4)F.S.; maintain a current CPR certification from an instructor that is approved to provide training by the American Red Cross or the American Heart Association, and a statement from a health care professional, dated with the last 6 months, stating that the contractor is free from communicable diseases as described in Rule 59A-18.005(6)F.A.C; 400.506(6)(a)FS. Be limited to assisting a patient in accordance with s.400.506(10)(b), F.S.;

Responsibilities:

1. Be limited to assisting a patient in accordance with s.400.506(10)(b),F.S.;
2. Be responsible for documenting services provided to the patient or client and for filing said document with the Nurse Registry on a regular basic. These services logs will be stored by the Nurse Registry in the client's file. Service logs shall include the name of the patient/client and a listing of the services provided;
3. Be responsible for observing appearance and gross behavioral changes in the patient and reporting these changes to the caregiver and the Nurse Registry responsible for assessing the case when giving care in the home or to the responsible facility employee if staffing in a facility.
4. Be responsible to maintain a clean, safe and healthy environment, which may include light cleaning and straightening of the bathroom, straightening the sleeping and living areas, washing the patient's dishes or laundry, and such tasks to maintain cleanliness and safety for the patients.
5. Perform other activities as documented by the registered nurse, concerning activities for a specific patient and restricted to the following:
    a. Assisting with the changes of a colostomy bag, reinforcement of dressing;
    b. Assisting with the use of devices for daily living such as a wheelchair or walker;
    c. Assisting with prescribed range of motion exercise;
    d. Assisting with prescribed ice cap or collar;
    e. Doing simple urine tests for sugar, acetone or albumin;
    f. Measuring and preparing special diets; g. Measuring temperature, pulse, respiration or blood pressure.

6. Be prohibited from changing sterile dressings, irrigating body cavities such as giving an enema, irrigating a colostomy or wound, performing gastric irrigation or internal feeding, catheterizing a patient, administering medications, applying heat by any method, or caring for a tracheotomy tube.
7. Report incidents and accidents immediately to the Nurse Registry.

CERTIFIED NURSING ASSISTANT (CNA) / HOME HEALTH AIDE (HHA) (2)

JOB DESCRIPTION

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read, and I fully understand all of the above and what is expected of me as a HHA/CNA.

_______________________________ _________________

Signature Date

REFERRED INDEPENDENT CONTRACTOR AGREEMENT

This REFERRED INDEPENDENT CONTRACTOR AGREEMENT (the "Agreement") is entered into this_____ day of___________, 20__, by and between____and TRUSTED HOME CARE SERVICES, INC. ("TRUSTED"), to facilitate the introduction and referral of Clients/Patients to the Contractor by TRUSTED.

1. I understand, acknowledge, and agree that TRUSTED is a Nurse Registry, as defined in Section 400.462 of the Florida Statutes, holding license numbers 30211550, 30211662, 30211967 issued by the State of Florida Agency for Health Care Administration, and that TRUSTED was established under and engages in business in accordance with those provisions of Chapter 400, Part III and Chapter 408, Part II of the Florida Statutes and Chapter 59A-18 of the Florida Administrative Code that apply to Nurse Registries.
2. I understand, acknowledge, and agree that as a Nurse Registry established under and engaging in business in accordance with Chapter 400, Part III and Chapter 408, Part II of the Florida Statutes and Chapter 59A-18 of the Florida Administrative Code, TRUSTED provides referrals for health-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, and homemakers, who are compensated by fees as independent contractors.
3. I understand, acknowledge, and agree that, in accordance with Section 400.506(6)(d) of the Florida Statutes, at all times during my relationship with TRUSTED, I will be an independent contractor and not an employee of TRUSTED or any affiliate thereof regardless of any obligations imposed on TRUSTED as a nurse registry under Chapters 400 or 408 of the Florida Statutes. Accordingly, I waive, to the fullest extent permitted by law, any and all claims that I have or may have, or may hereafter have, based on any assertion under any applicable federal, state, or local law, regulations, rule, or ordinance, that my relationship with TRUSTED (or any affiliate thereof) is or at any time was anything other than an independent contractor.
   Independent Contractor Initials: __________
4. I understand that as a Nurse Registry, in accordance with Section 400.506(19) of the Florida Statutes, TRUSTED will not monitor, supervise, manage, or train me in connection with the services to be provided by me under this Agreement to the Client/Patient, nor will TRUSTED evaluate my services. TRUSTED additionally will not control or direct the details and means by which I perform services for the Client/Patient, and I shall be free to exercise my own judgment with respect to the means and methods for fulfilling my obligations to the Client/Patient, subject to all applicable laws, rules, and regulations relating to such services.
5. I understand and agree that the Client/Patient and only the Client/Patient is the individual or entity that determines my schedule, the times I am to start and stop providing services, what days I will provide services, how my services are to be performed, and the method by which my services are provided, not TRUSTED.
6. I acknowledge and agree that I independently negotiated my compensation directly with the Client/Patient, and that TRUSTED did not set or determine the compensation to have paid me under this Agreement. Under the agreement between me and the Client/Patient, the following will be my compensation for my services under this Agreement:

   $____________per hour (minimum)____________Independent Contractor Initials

   $____________per visit (minimum)____________Independent Contractor Initials

   For my convenience, I expressly request and authorize Trusted to process and make the 1099 payments to me outlined above (in lieu of receiving payments from the Patient/Client for my services).____________Independent Contractor Initials

   I agree to submit the necessary visit/services related information requested on forms provided by the Patient/Client and/or Trusted in order to determine the appropriate compensation to be issued. I acknowledge and recognize that, although Trusted is agreeing to process the payments on behalf of the Patient/Client, should Trusted not receive the related funds from the Patient/Client or applicable government funding source, I will not hold Trusted responsible for any nonpayment for services.

7. I understand and agree that as an independent contractor, I am solely responsible for all federal, state, and local taxes on my earnings, including but not limited to Social Security and self-employment taxes, and I agree to hold harmless, indemnify, protect, and defend TRUSTED against any claims brought against it or any damages, fines, or penalties asserted against it if I do not pay taxes on compensation paid to me under this Agreement.
8. I understand and agree that as an independent contractor, I am not eligible to receive unemployment compensation benefits.

9. I understand and agree that as an independent contractor, it is my responsibility to provide my own Worker's Compensation coverage at my own expense. I understand and agree that as an independent contractor I am solely responsible for all injuries and related expenses and lost wages that I may incur while working with my patients/clients. I understand and agree that because I am an independent contractor, TRUSTED does not provide me with Worker's Compensation coverage and I will not attempt to hold TRUSTED or any of its officers, employees, or agents liable if I fail to provide my own Worker's Compensation coverage.
10. I understand and agree that I am not obligated to provide services only to Clients/Patients of TRUSTED, but may obtain referrals from other nurse registries, or work opportunities.
11. I understand and agree that TRUSTED does not and will not provide me with, or reimburse me for the cost of, any tools, equipment, materials, supplies, uniforms, or any other items to facilitate my providing of services to Clients/Patients. I am solely responsible for any and all such tools, equipment, materials, supplies, uniforms, or other items necessary to provide services to the Client/Patient.
12. I understand and agree that I am expected to work only within the scope of my license(s) or certification(s).
13. I agree to notify TRUSTED should any of my licenses or certifications expire, be suspended, or be revoked. I additionally agree to promptly notify TRUSTED if any complaint is filed against me by any local, state, or federal agency in connection with my providing services to any Client/Patient or otherwise in connection with my providing of healthcare-related services to any person or entity.
14. I understand and agree that I must comply with those TRUSTED rules and regulations that apply to nurse registries and to me as an independent contractor receiving a referral from a nurse registry.
15. I understand and agree that I must respect and protect the rights of all Clients/Patients with whom I come in contact.
16. I understand and agree that, in order to terminate this Agreement, I must notify TRUSTED in writing, no less than thirty (30) days prior to my last date of service. I understand and agree that TRUSTED may immediately terminate this Agreement at any time, for any reason.
17. I understand and agree that, in accordance with applicable Florida Statutes and the Florida Administrative Code, the following statements shall apply to how I conduct my business as an independent contractor and shall apply during the term of this Agreement and my providing of services to Clients/Patients hereunder:

a. The Independent Contractor maintains a separate business with his/her own work facility, transportation, equipment, materials or similar accommodations.
b. The Independent Contractor holds or has applied for a federal employer identification number, unless the Independent Contractor is a sole proprietor who is not required to obtain a federal employer identification number under state or federal requirements.
c. The Independent Contractor performs or agrees to perform specific services or work for specific amounts of money and controls the means of performing the services or work.
d. The Independent Contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform.
e. The Independent Contractor is responsible for the satisfactory completion of work or services that he or she performs or agrees to perform and is or could be held liable for a failure to complete the work services.
f. The Independent Contractor receives compensation for work or services performed for a commission or on a per-job or competitive bid basis and not on any other basis.
g. The Independent Contractor may realize a profit or suffer a loss in connection with performing work or services.
h. The Independent Contractor has continuing or recurring business liabilities or obligations.
i. The success or failure of the Independent Contractor's business depends on the relationship of business receipts to expenditures.

18. I understand the rights and obligations under this Agreement are personal to me and may not be assigned or transferred to any other person, firm, or corporation without the prior express written consent of TRUSTED. I may, however, at my own expense and with TRUSTED's prior written consent, employ such qualified and appropriately-licensed or certified assistants, employees, and such other persons as I deem necessary to perform services under this Agreement, provided that I remain ultimately responsible for all work performed by all such persons and for the services, and for fulfilling my obligations under this Agreement. TRUSTED shall neither control, direct, nor supervise, any such persons retained or employed by me.

19. HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA). As an Independent Contractor, I am required to protect the confidentiality of patients' medical and health information. I understand that all medical, financial, and personal information is confidential, and I will protect such patient information from unauthorized viewing, discussion, and disclosure.

20. ARBITRATION. By signing below, the parties to this Agreement agree to resolve any disputes, complaints, causes of action, or other claims between them, including any claims arising under or relating to this Agreement, through private, confidential, binding arbitration pursuant to the JAMS Employment Arbitration Rules and Procedures (www.jamsadr.com).

a. Either party shall initiate the arbitration process by delivering a written request for arbitration to the other party within the time limits which would apply to the filing of a civil complaint in Florida state court. A late request will be void. If the parties are unable to agree upon a single neutral arbitrator within a period of 10 calendar days, TRUSTED will obtain a list of arbitrators from JAMS. An arbitrator shall thereafter be selected off of this list using the process of alternate strikes, with the party requesting arbitration having the first strike. The arbitrator shall be bound by the provisions and procedures set forth in the JAMS Employment Arbitration Rules and Procedures. The arbitrator shall determine the prevailing party in the arbitration. All administrative expenses of arbitration, *e.g.*, arbitrator's fees, court reporter fees, etc., will be borne equally by both parties. The arbitrator shall have the authority to order any legal and equitable remedy which would be available in a civil or administrative action on the claim(s) at issue, including an award of attorneys' fees and costs. Except as may be otherwise provided by the arbitrator, each party shall bear its own respective attorneys' fees and costs.

b. Arbitration shall be the exclusive means of resolving any dispute(s) arising under or relating to this Agreement or otherwise related to my relationship with TRUSTED, and no other action shall be brought in any court or administrative forum for such disputes.

c. Except as otherwise required under applicable law, the parties expressly intend and agree that (i) class action, collective action, and representative action procedures shall not be asserted, nor will they apply, in any arbitration proceeding pursuant to this Agreement; (ii) neither party will assert any class action, collective action, or representative action claims against the other party in arbitration or any other forum; and (iii) each party shall only submit that party's own individual claim(s) in arbitration and will not seek to represent the interests of any other person.

d. If any court of competent jurisdiction declares that any part of this Section 20 of this Agreement pertaining to arbitration of disputes is illegal, invalid, or unenforceable, such a declaration will not affect the legality, validity, or enforceability of the remaining parts of the Agreement, and the illegal, invalid, or unenforceable part will no longer be part of this Agreement.

e. THIS ARBITRATION PROVISION IS A WAIVER OF ALL RIGHTS TO A CIVIL JURY OR BENCH TRIAL FOR ALL DISPUTES BETWEEN THE PARTIES ARISING OUT OF OR RELATING TO THIS AGREEMENT, TO THE EXTENT ALLOWED BY LAW.

21. MISCELLANEOUS

a. This Agreement shall be binding upon and for the benefit of the undersigned parties, their successors and assigns, and TRUSTED affiliates.

b. Failure to enforce any provision of this Agreement by a party shall not constitute a waiver of any term hereof by such party.

c. If any provision of this Agreement or the application of any provision to any party or circumstance shall be found by a court of competent jurisdiction to be prohibited by or invalid under applicable law, the parties agree that such invalid or unenforceable part may be severed or modified to permit the Agreement to be enforced to the maximum extent permitted under law, with the remaining portions unaffected by the invalidity or unenforceability.

d. This Agreement may be executed in counterparts and signatures exchanged by facsimile or .pdf are effective for all purposes hereunder to the same extent as original signatures, except as otherwise provided herein.

e. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Florida, without regard to conflict of laws principles.

f. This Agreement is the final, complete, and exclusive agreement of the parties with respect to the subject matter hereof and supersedes and merges all prior discussions between the parties relating to those subjects.

g. No modifications or amendments of this Agreement, nor any waiver of any rights or liabilities under this Agreement will be effective unless in writing signed by the party to be charged (and if by TRUSTED, signed by an authorized TRUSTED representative.

h. The prevailing party in any action arising out of or in any way related to this Agreement shall be entitled to recover from the other party all expenses arising out of such action including, without limitation, reasonable attorneys' fees, court costs, and related taxable and non-taxable expenses.

Name:

Signature:

Date:

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ ________

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ - ☐☐ - ☐☐☐☐

or

Employer identification number

☐☐ - ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

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/Contractor Name (Printed)

____

Employee/Contractor Signature

____

Date

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.

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

PRIVACY STATEMENT

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: The requesting agency and/or the agency conducting 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

Trusted Homecare Services
A Homecare Company You Can Trust

Attestation Form: Original Signature

I, the undersigned Independent Contractor/Caregiver referred by Trusted Homecare Services, do hereby acknowledge and attest that this is my original signature.

____ ____________________
Independent Contractor/Caregiver – Name (Print) Date

____ ____________________
Independent Contractor/Caregiver – Signature Date

____ ____________________
Name and Title – Trusted Homecare Service Personnel Date

Trusted Homecare Services Employee Authorized signature. By this signature, I hereby witness to the authentication of the Independent Contractor/Caregiver’s signature.

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes,** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name: Trusted Homecare Services
Address of Health Care Provider:

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photo optical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: ______________________

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: ______________________

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening:____

Screening conducted by: Date of Prior Screening: __________

☐ Agency for Healthcare Administration
☐ Department of Health
☐ Agency for Persons with Disabilities

☐ Department of Elder Affairs
☐ Department of Financial Services
☐ Department of Children and Families

Attestation

Under penalty of perjury, I, ________________________________, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature ____ ______________ Date

Trusted Homecare Services
A Homecare Company You Can Trust

CODE OF ETHICS

TRUSTED HOMECARE SERVICES ensure that independent contractors recognize the importance of providing quality patient care. Such care must be provided in accordance with the following Code of Ethics:

We will consistently strive to provide quality services to our clients and to the community in accordance with the highest professional and ethical standard possible.

We will abide by all Local, Federal and State Laws, Rules Ethical Regulations and ordinances.

This registry will not discriminate on a basis of age, sex, race, creed, color, national origin or disability.

We will recognize and respect the client’s right to privacy and will prevent unauthorized disclosure of medical and financial information.

We will be actively involved with the community to help implement and improve the standards of patient care and control health care costs.

We will assist in planning and securing to meet total client needs in cooperation with community resources and agencies.

Trusted Homecare Services
A Homecare Company You Can Trust

MAINTAINING A PROFESSIONAL IMAGE

YOUR APPEARANCE AND ETHICS REFLECT YOUR PROFESSIONALISM

Because independent contractors represent TRUSTED HOMECARE SERVICES image, all workers should be well groomed and dressed in proper attire according to OSHA dress requirements. Failure to abide by the dress code could result in the process of Referral Independent Contractor Agreement termination.

ACCEPTABLE ATTIRE INCLUDES:

- White Uniform – clean and presentable
- Scrubs – clean and presentable
- White or black shoes (no sandals, open back or open toe)
- Hose or socks
- Jewelry
- All independent contractors are expected to practice daily hygiene

PERSONAL PHONE CALLS

Independent contractors are not permitted to make any personal calls by using the client's phone while on duty. If an emergency call must be made, you must ask the client for approval. If you're working in a full-time position such as live-in, you can make local phone calls with the permission of the client. **No long-distance** calls are allowed under any circumstance on the client's phone.

HANDLING MONEY

Do not accept money from the client. Independent contractors must produce receipts for all purchases made on behalf of the client.

SOLICITATION

Solicitation while on duty interferes with the business of the Registry. Solicitation of any kind is not permitted.

PUNCTUALITY

All Independent Contractors are expected to be at their work area on time. If any emergency is likely to cause tardiness of more than fifteen minutes, telephone your client and give him/her the expected time of arrival.

Please DO NOT call the office after business hours for availability. (The person on-call only is available for EMERGENCY).

All request not to be referred or scheduled to an assignment must be submitted 5 business days prior if already referred to the assignment so that the Registry may arrange for appropriate care for the patient/client.

CHANGES WITH PATIENT

All abnormalities observed with patient must be reported to the registry office immediately. This includes aides that are on staff in a facility. (**PLEASE NOTE THAT THE SUPERVISOR AT THE FACILITY MUST ALSO BE NOTIFIED).**

TIME OFF

If you are unable to report to an assignment due to unforeseen circumstances, the office must be notified within 48-72 hours in order to provide a suitable replacement.

WORKERS COMPENSATION AND LIABILITY INSURANCE

Since you are an independent contractor, in accordance with your agreement with the Registry you are required to purchase and maintain your own Worker's Compensation and Liability Insurance.

____

INDEPENDENT CONTRACTOR NAME (please print)

____

INDEPENDENT CONTRACTOR SIGNATURE

____

DATE

ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATIONS BY INDEPENDENT CONTRACTORS REFERRED BY A NURSE REGISTRY

Patients who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a patient whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person **may occur only upon a documented request by and the written informed consent of a patient or the patient's surrogate, guardian, or attorney in fact.** For purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, and topical ophthalmic, optic and nasal dosage forms, including solutions, suspensions, sprays and inhalers.

1. Assistance with self-administration of medication includes:
   a. Taking the medications in its previously dispensed, properly labeled container, from where it is stored and bringing it to the patient.
   b. In the presence of the patient, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.
   c. Placing an oral dosage in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth.
   d. Applying topical medications.
   e. Returning the medication container to proper storage.
   f. Keeping a record of when a patient receives assistance with self-administration under this section.

2. Assistance with self-administration does **not** include:
   a. Mixing compounding, converting, or calculating medication doses except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing tablet as prescribed.
   b. The preparation of syringes for injections or the administration of medications by any injectable route.
   c. Administration of medications through intermittent positive pressure breathing machines or nebulizer.
   d. Administration of medications by way of a tube inserted in a cavity of the body.
   e. Administration of parental preparations.
   f. Irrigations or debriding agents used in the treatment of a skin condition
   g. Rectal, urethral, or vaginal preparations.

Trusted Homecare Services
A Homecare Company You Can Trust

h. Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed", unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent patient.
i. Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

3. Assistance with the self-administration of medication by an unlicensed person as described in this section does not constitute administration as defined in **s.465.003.**

4. The agency may be rule establish procedures and interpret terms as necessary to administer this section.

____________________________________ ____________________
INDEPENDENT CONTRACTOR'S SIGNATURE DATE

Trusted Homecare Services
A Homecare Company You Can Trust

CONFIDENTIALITY STATEMENT

All medical, financial and personal information is confidential and is protected from unauthorized viewing, discussion and disclosure. All independent contractors have the right to confidentiality regarding their personnel records and medical information.

In order to assure and protect confidentiality, independent contractors may look at, use, or disclose patient information only as it relates to the performance of their duties. Any unauthorized viewing, discussion or disclosure will provide ground for termination. Whenever it is questionable as to what information is confidential it is your responsibility to discuss the matter with your supervisor before any breach of confidentiality occurs.

I acknowledge I have read this statement concerning confidential information and agree to uphold the expectations of this statement.

____ ____________________
Independent Contractor’s Signature Date

Trusted Homecare Services
A Homecare Company You Can Trust

DRIVER'S SAFETY AGREEMENT

My signature below verifies that I have read and understand the following:

1. Holding a current valid Florida driver's license and carrying liability insurance on personally owned vehicles used for company business.
2. Using agency vans and automobiles only for independent contractors transporting and related company business.
3. Taking the most direct route to my destinations and deviating only for work related reasons.
4. Locking doors and keeping windows closed when vehicle is parked and not in use.
5. Wearing seatbelts when vehicle is in use.
6. Not transporting or providing rides to unauthorized people during working hours.
7. If an accident occurs, completing an Accident Report Form and notifying the office immediately.
8. Not admitting any liability if in an accident.
9. Personally resolving any citations received for violation of Florida driving regulations.
10. Understanding that suspension or revocation of my driver's license will automatically negate my privilege to drive as a representative of this registry.

________________________________ ________________

Independent Contractor's Signature Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (H.I.P.A.A.)

The Privacy Rule establishes safeguard to protect the confidentiality of medical information and other personal health information.

TRUSTED HOMECARE SERVICES in compliance with HIPAA is committed to maintain the safeguarding of private health and medical information such as:

- Notifying patients about their privacy rights and how their information may be used.
- Adopting and implementing privacy procedures for its operation.
- Training independent contractors so that they understand the privacy procedures.
- Designating an individual to be responsible for seeing that the privacy procedures are adopted and followed.
- Securing patient records containing individually identifiable health information so that they are not readily available to unauthorized individuals or those who do not need them.
- Informing Independent contractor's pre and post orientation/registration of the H.I.P.A.A. Laws by reviewing and providing printed materials on the PRIVACY RULE. TRUSTED HOMECARE SERVICES will ensure that documented proof of acknowledgement of receipt of such documents is maintained on the Independent Contractors' Registration files.

Individually Identifiable Health Information can be evident in the following forms:

Invoices
Facsimile
Paper
E-Mail
Orally
Computer systems

Trusted Homecare Services
A Homecare Company You Can Trust

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (H.I.P.A.A.)

TRUSTED HOMECARE SERVICES in safeguarding patient medical/health information from unauthorized viewing in addition to the old system of paper records in locked filing cabinets has implemented the following:

A. Urgent notices/warning of fax cover sheets regarding legal consequences of viewing P.H.I. by unauthorized persons.
B. Requires written authorization from patients and their responsible parties for disclosing medical or personal health information.
C. Individuals who claim to be patient's legal representative are required to provide legal documented evidence as proof, prior to disclose of any Protected Health Information (P.H.I.)
D. No health or medical information will be disclosed to any unauthorized person via telephone by Representative THIS IS PROHIBITED. (Note: An employee-independent contractor is subject to immediate termination of their Referral Independent Contractor Agreement for violating this rule)
E. All independent contractors are required to hand deliver or mail their activity sheets and assignment sheets to TRUSTED HOMECARE SERVICES Nursing Registry. A shredding machine is placed in the office for the appropriate disposal of any written document that is considered "trash" and unacceptable for filing in a patient's records or register files.

ACKNOWLEDGEMENT OF RECEIPT

By signing below, I am acknowledging that I have received, read and understand foregoing statements in this document and will adhere to them accordingly.

___________________________________ ___________________
Independent Contractor's Signature Date