Employer/Employee Agreement

EMPLOYER INFORMATION

Employer Name: Alliance Health Services LLC

Address: 313 Dark Star Way
Glen Burnie, Maryland 21060

Telephone: 410-242-8974

Fax: 410- 553-0213

EMPLOYER INFORMATION

Employee Name: _Address: _Telephone:

JOB INFORMATION

Position Title: _Job Description:

Dress Code: You are encouraged to wear scrubs. However if you do not have scrubs, you may wear business casual clothing. NO JEANS scanty toys spaghetti strapped outfits, scanty revealing tops, see-through clothing, etc are not allowed.

What the Agency expects from Its employees

Attendance Policy:

Advance notice to request for time off: At least 3 days in advance.

You are expected to arrive on time for ALL assignments. The Agency must be notified by phone if:

a. An emergency or situation arises which causes you to be late by five or more minutes.

b. You will be absent from your assignment.

Without calling the office, these situations are called NO CALL NO SHOW and are subject to immediate termination.

Never leave any assignment early without first calling to inform your scheduling coordinator.

Never abandon a client assigned to you.
An employee who leaves an assigned client unattended at any time during the assigned time will be charged with abandonment and terminated immediately.

Cancellation Policy:

A minimum of eight (8) hours of cancellation notice must be given at all times unless you are involved in an emergency. Should you decide an assigned client must be removed from your schedule, the office requires a minimum of one week's notice to arrange a change of worker 2 weeks' notice is preferred.

Once you have been given an assignment. no more than 2 cancellations will be tolerated.

Incident/Accidents

INCIDENT/ACCIDENTS REPORTING ACKNOWLEDGEMENT

I have been thoroughly informed by **Alliance Health Services LLC** that I MUST report ALL incidents/accidents and any medical, physical, or mental changes in my clients Immediately to the Nursing Director/Supervisor and or Scheduling Coordinator.

Scheduling Coordinator.

I further understand that if, even a minor injury, I am required to report that incident to my office as soon as possible after an injury. preferably on the day of the Injury.

Employee Printed Name: _Signature: Date: _____

Acknowledgment and Understanding of Zero Tolerance Sexual Abuse Policy

I acknowledge that I have received and read the sexual abuse policy and/or have had it explained to me. I understand that the organization will not tolerate any employee, volunteer, board member or third party who commits sexual abuse. Disciplinary actions will be taken against those who are found to have via-omitted sexual abuse. I understand that it is my responsibility to abide by all rules contained in the policy I also understand how to report incidents of sexual abuse as outlined in the abuse policy, including retaliating against any employee/volunteer exercising his or her rights under the policy.

Employee Printed Name: _Signature: Date: _____

Compensation Policy

Employee Pay: Employees are paid based on the number of hours workedcalculated on 15 minute increments.

Pay Method:

By check sent by regular mail or by direct deposit (Please provide a copy of voided check if you would like to be paid by direct deposit).

Pay Frequency:

Caregivers are paid by check or direct deposit on the 15th & every last day of the month - twice a month.

Payroll Deductions:

Compulsory: Social Security and state and federal taxes are deducted from the money that you earn.

Benefits:Medical: N/A
Dental: N/A
Disability: N/A
Retirement: N/A
Sick Leave: N/A
Bereavement Leave: N/A
Domestic Leave: N/A
Parental Leave: N/A
Clothing Allowance: N/A
Overtime:

Legitimate Expenses: Work-related pre-approval expenses such as travel (driving the client from one point to another in your vehicle) at the request of the **Alliance Health Services LLC** and other expenses related to the services employee was hired to perform. IRS standard mileage allowance of 50.54 per mile applies when you drive a client in your vehicle.

CONFLICT OF INTEREST

Many homecare employees work for more than one company at the same time. It is essential that you let us know if you are working for another organization. Remember that any client you service for us are OUR clients. Should you ever decide to leave us for any reason, clients you are servicing for us MAY NEVER be encouraged to transfer to another company where you might be working. This is clearly a conflict of interest and will not be tolerated. Our legal department will be notified immediately should this occur.

Employee Printed Name:

Signature: Date: _____

Do's And Don'ts of Home Care

While making your assigned visits please be aware that the following guidelines are always in place:

Do's
• Be courteous and pleasant at all times.
• Wear scrubs while making all visits.
• Try to do all you can to bring joy to your clients (positive attitude).
• Report any unusual occurrence to the office immediately.
• Call the office immediately if the client does not answer their door for a scheduled visit. Failure to notify the office may be considered abandonment, especially if the client has had a medical emergency and is on the floor without your knowledge. DON'T assume they aren't home. CALL THE OFFICE.
• Follow your schedule at all times WITHOUT MAKING ANY CHANGES.
• Interact with the scheduling coordinator often, especially if you are available to work but do not have scheduled visits.

Don't
• Do not bring your own personal issues to your clients.
• Do not use a client's phone for personal calls.
• Do not use your cell phone for texting or for any reason while with your patient (unless it is an emergency).
• Do not ever borrow money from a client for any reason.
• Do not bring family members & friends to your client's home (or your workplace).
• No window washing (except an occasional wipe down of a window the client commonly sits and looks out from).
• No raking leaves or snow shoveling.
• No transporting client's in your car unless you have a signed consent/authorization.

_____
Employee First & Last Name

_____ _____
Employee Signature Date

Alliance Health Services LLC

HIPPA
Confidentiality/Privacy of Health Information Statement

Agency personnel must read and sign their acknowledgment of the following statement:

One of the most valuable assets of any home care agency is proprietary information about employees, clients, care plans, services and systems. Information that is not public is considered proprietary.

By contracting with **Alliance Health Services LLC**, I agree to carefully refrain from discussing any client's health information, condition or personal affairs with anyone outside the agency, unless expressly authorized in writing to do so. I will not share any medical information with other clients or visitors without clear instruction provided to the agency.

I acknowledge that all the information seen or heard regarding clients, directly or indirectly, is completely confidential and is not to be discussed, even with my family or coworkers. My job as an employee requires that I govern myself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breech of professional ethics, but can also involve an employee in legal proceedings. I will not share or release any information about clients or the agency with the media or anyone else during employment and after termination. This is essential for protection of both the client and Agency.

HIPAA, the Health Insurance Portability and Accountability Act of 1996, imposes standards for maintaining the privacy of individual identifiable information that we work with, transmit, or maintain, regardless of the form. The section of the law governing these standards is commonly known as The Privacy Rule. All employees may not disclose an individual's Protected Health Information (PHI) outside the guidelines set forth in the law.

I have read and understood the above statement and agree to abide by these policies. I understand that a breach of policy may result in disciplinary action and possible dismissal or termination.

Print Name _____ Date _____

Personnel Signature _____ Date _____

Witness Signature _____ Date _____