COASTAL HEALTH CARE SYSTEMS INC.

PERSONNEL FILE

SECTION 1

- **EMPLOYMENT APPLICATION**
- **RESUME**
- **REFERENCES RECORDS (2)**
- **EMERGENCY CONTACT INFORMATION**

SECTION 2 (copies NEEDED)

- **LICENSE COPY**
- **SOCIAL SECURITY CARD**
- **CPR CARD**
- **DRIVER'S LICENSEOR OR GREEN CARD**
- **AUTO INSURANCE**
- **TB OR CHEST X-RAY RESULTS**
- **COVID-19 VACCINATION RECORD/PROOF OF EXEMPTION**
- **IMMUNIZATIONS**

SECTION 3

- **ORIENTATION CHECKLIST at Hire**
- **JOB ACCEPTANCE STATEMENT**
- **JOB DESCRIPTION**
- **PERFORMANCE EVALUATION (90 DAYS AND YEARLY)**
- **SKILLS COMPETENCY EVALUATIONS (ON HIRE AND YEARLY)**
- **IN-SERVICES REQUIRED ON-HIRE AND THEN YEARLY - INSERT CERTIFICATES AND TESTS**
- **CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION**

COASTAL HEALTH CARE SYSTEMS INC.

- **E-SIGNATURE AGREEMENT**
- **FIELD PRACTICES STATEMENT**
- **CONFIDENTIALITY STATEMENT**
- **HIPAA CONFIDENTIALITY AGREEMENT**
- **CORPORATE COMPLIANCE STATEMENT**
- **POLICIES AND PROCEDURES STATEMENT**
- **PROTECTIVE EQUIPMENT STATEMENT**

- **PAYROLL FORMS (W-9)**

- **PHYSICAL-FREE OF COMMUNICABLE DISEASE STATEMENT**
- **TB QUESTIONAIRRE ON YEARS BETWEEN CHEST X-RAYS**
- **HEPATITIS DECLINATION/ACCEPTANCE FORM (EVIDENCE OF HEPATITIS VACCINE COMPLETION IF THE EMPLOYEE MARKS THE FORM THAT THEY HAVE COMPLETED THE SERIES)**

COASTAL HEALTH CARE SYSTEMS INC.

APPLICATION FOR EMPLOYMENT

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

PERSONAL

Date

Last Name **First** **Middle**

Home Phone

Street Address

Business Phone

City, State, Zip Code

Date of Birth

S.S. #

Emergency contact (person not living with you)

Have you ever applied for employment with this Agency? Yes No

How many hours a week are you available for work?

Are you legally eligible for employment in the United States? Yes No

How did you learn of our organization? Newspaper Ad Agency employee Other

Are you willing to work: Evenings? Weekends?

Position applying for:

COASTAL HEALTH CARE SYSTEMS INC.

EDUCATION:

School Name	Location of School	Course of Study	Years of	Degree/
Diploma				**Study**
College:				
_____	_____	_____	____	____
_____	_____	_____	____	____
Vo-Tech or Trade:				
_____	_____	_____	____	____
_____	_____	_____	____	
High School:				
_____	_____	_____	____	____
_____	_____	_____	____	____
Other:				
_____	_____	_____	____	____
_____	_____	_____	____	____

Employment:

List the last five years' employment history, starting with the most recent employer.

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

2. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
From _____ To _____
_____
City State Zip Code Starting Pay: _____

COASTAL HEALTH CARE SYSTEMS INC.

Job Title and describe your work: _____ Reason for leaving: _____

_____ _____

_____ _____

3. Company Name: Telephone:

_____ _____

Address: _____ Dates of Employment: _____

From T

_____ _____ o _____

_____ Starting Pay:

City State Zip Code _____

Reason for leaving:

Job Title and describe your work: _____ _____

COASTAL HEALTH CARE SYSTEMS INC.

APPLICATION FOR EMPLOYMENT

Was your last name different from your present name during the above listed jobs?
Yes_____ No_____

If yes, what was your name? _____

Are you currently employed? Yes _____ No _____
Do you have reliable transportation? Yes No

_____ _____

PROFESSIONAL REFERENCES

Persons who can furnish information about job performance.

1. Name: _____ Telephone: _____

Fax: _____

Address: _____

2. Name: _____ Telephone: _____

Fax: _____

Address: _____

3. Name: _____ Telephone: _____

Fax: _____

Address: _____

GENERAL

Have you ever been convicted of a crime in the past 5 years, barring employment in a Home?

Care and community support Agency? Yes No

Conviction will not necessarily disqualify an applicant from employment.

If yes, describe in full: _____

_____

_____

_____

Are you capable of performing the job set forth in the job description? Yes No If you answered No, which job requirement can you not meet? _____

_____

_____

_____

COASTAL HEALTH CARE SYSTEMS INC.

APPLICATION FOR EMPLOYMENT

CREDENTIALS/SPECIALIZED SKILLS & QUALIFICATIONS/EQUIPMENT OPERATED

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

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

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

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

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

DATE:_____ **SIGNATURE**_____

COASTAL HEALTH CARE SYSTEMS INC.

APPLICANT REFERENCE CHECK (1)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employees listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

****** FOR OFFICE USE ONLY**

EMPLOYMENT VERIFICATION: **To be completed by employer:**

INTERVIEWER: Introduce yourself, identify our company) "One of your former/current employees, _____ (name), has applied for employment at our company as a _____ (job title). Hopefully you will give me some insight on (him/her) and whether this is a suitable position for (him/her). May I ask you a few questions?'

What was/is his/her position? _____ What were the dates of his/her employment: _____

What was/is your relationship with him/her? (e.g., supervisor, co-worker, etc) _____

If you had an opening today for the same job, would you hire him/her? Yes ___ No _____

How would you rate his/her overall performance on scale 0-10? _____

Was he/she _____ dependable? _____ work well with other? ___exhibit initiative

COASTAL HEALTH CARE SYSTEMS INC.

Name of Interviewer: _____ Date: _____

COASTAL HEALTH CARE SYSTEMS INC.

APPLICANT REFERENCE CHECK (2)

To Whom It May Concern:

The applicant named below has submitted an application for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name**:** _____ Date of Application**:** _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employees listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

****** FOR OFFICE USE ONLY**

EMPLOYMENT VERIFICATION: **To be completed by employer:**

INTERVIEWER: Introduce yourself, identify our company) "One of your former/current employees, _____ (name), has applied for employment at our company as a _____ (job title). Hopefully you will give me some insight on (him/her) and whether this is a suitable position for (him/her). May I ask you a few questions?'

What was/is his/her position? _____ What were the dates of his/her employment? _____

What was/is your relationship with him/her? (e.g., supervisor, co-worker, etc) _____

If you had an opening today for the same job, would you hire him/her? Yes ___ No _____

How would you rate his/her overall performance on scale 0-10? _____

Was he/she _____ dependable? _____ work well with other? ___exhibit initiative

Name of Interviewer: _____ __ Date: _____

COASTAL HEALTH CARE SYSTEMS INC.

COASTAL HEALTH CARE SYSTEMS INC.

Employee Emergency Contact Information

Employee Name: _____

Current Address: _____

Home Phone: _____ Cell Phone: _____

Next of kin: _____ Phone: _____

Relationship: _____ Address: _____

_____

*In case of emergency, please contact:

Name:
_____

Phone: _____

Address: _____

Relationship:
_____

*Please notify this Agency immediately if any of the emergency contact information changes.

COASTAL HEALTH CARE SYSTEMS INC.

ORIENTATION PROGRAM

	Initials		Initials
Agency Mission, Vision and Plan and Organizational Chart		Advance Directives	
Types of Care Provided by the Agency including Information Provided to Patients Regarding Charges		Policies and Procedures HIPAA	
Personnel Policies, Job Descriptions and Professional Boundaries of All Disciplines		Training Specific to Job Descriptions	
Cultural diversity Community Resources		Patient Rights and Grievance Policy	
Ethics, Conflict of Interest and Confidentiality of Patient Information		Supervision and Evaluation	
Home Safety (including Bathroom, Electrical, Environment, Fire and Hazards)		Safety Issues in the Home (Including Security and Guns in the Home)	
Emergency Preparedness Plan/Actions to Take in the Event of a Disaster		Actions to Take in Unsafe Situations	
OSHA Requirements, Safety and Infection Control in the Home/Standard Precautions		Patient Care Responsibilities Including Charges for Service/Care	
Incidences and Occurrences reporting Quality Assurance		Understanding and coping with Alzheimer's Disease and Dementia	
Identifying and Reporting Abuse, Neglect and Exploitation		Fraud/Abuse/Corporate Compliance, False Claims, False Statements, Whistle Blowing	
Documentation - Record Keeping		ID Badge Issued Medical Device/Hazards reporting	
Print Name		**Title**	
Employee Signature		**Date**	
Print Employer Witness Name		**Title**	
Employer Signature		**Date**	

COASTAL HEALTH CARE SYSTEMS INC.

TEXAS CRIMINAL HISTORY STATEMENT
I hereby profess that I have not been convicted of any following crimes which are a permanent automatic bar to employment by this agency.
•An offense under Section 19, Penal Code (criminal homicide);
•An offense under Section 20, Penal Code (kidnapping and false imprisonment);
•An offense under Section 21.02, Penal Code (continuous sexual abuse of a young child or children);
•An offense under Section 21.08, Penal Code (indecent exposure); •An offense under Section 21.11, Penal Code (indecency with a child);
•An offense under Section 21.12, Penal Code (improper relationship between educator and student);
•An offense under Section 21.15, Penal Code (improper photography or visual recording);
•An offense under Section 22.011, Penal Code (sexual assault);
•An offense under Section 22.02, Penal Code (aggravated assault);
•An offense under Section 22.021, Penal Code (aggravated sexual assault);
•An offense under Section 22.04, Penal Code (injury to a child, elderly individual, or disabled individual);
•An offense under Section 22.041, Penal Code (abandoning or endangering a child);
•An offense under Section 22.05, Penal Code (deadly conduct);
•An offense under Section 22.07, Penal Code (terroristic threat);
•An offense under Section 22.08, Penal Code (aiding suicide);
•An offense under Section 25.031, Penal Code (agreement to abduct from custody);
•An offense under Section 25.08, Penal Code (sale or purchase of a child);
•An offense under Section 28.02 Penal Code (arson);
•An offense under Section 29.02, Penal Code (robbery);
•An offense under Section 29.03, Penal Code (aggravated robbery);

•An offense under Section 33.021, Penal Code (online solicitation of a minor);

•An offense under Section 34.02, Penal Code (money laundering);

•An offense under Section 35A.02, Penal Code (Medicaid fraud); and

•An offense under Section 42.09, Penal Code (cruelty to animals); or

•A conviction under the laws of another state, federal law, of the Uniform Code of Military Justice for an offense containing

I also hereby profess that I have not been convicted of any of the following crimes within the past 5 years (applicable only to those hired on or after September 1, 2007, unless otherwise noted):

•An offense under Section 22.01, Penal Code (assault punishable as a Class A Misdemeanor or felony) [applicable to those hired on or after September 1, 2003];

•An offense under Section 30.02, Penal Code (burglary) [applicable to those hired on or after September 2003];

•An offense under Section 31, Penal Code (theft punishable as a felony)

[applicable to those hired on or after September 1, 20001].
•An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution punishable as a Class A Misdemeanor or felony)
•An offense under Section 32.46, Penal Code (securing execution of a document by deception punishable as a Class A Misdemeanor or felony) [applicable to those hired on or after September 1, 2003
•An offense under Section 37.12, Penal Code (false identification as peace officer); or
•An offense under Section 42.01(a)(7), (8), or (9), Penal Code (disorderly conduct).
I understand that it is required by law that HHCH check the Employee Misconduct Registry and, if appropriate, the Texas Nurse Aide Registry using my Social Security Number. And I further understand that any applicant listed on the Employee Misconduct Registry is unemployable at this agency.
I understand that if I have been placed on deferred adjudication community supervision for an offense listed above, successfully completed the period of deferred adjudication community supervision, and received a dismissal and discharge according to Section 5(c), Article 42.12, Code of Criminal Procedure, I am not considered convicted of the offense.
I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment.
I understand that all information obtained by this agency regarding my criminal history will remain confidential.
I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

Signature of Applicant:

Date of Birth (mm/dd/yyyy):

Social Security Number:

Printed Name:

COASTAL HEALTH CARE SYSTEMS INC.

Date:

COASTAL HEALTH CARE SYSTEMS INC.

JOB ACCEPTANCE STATEMENT

I have been given a copy of my job description. I have read and agree to the terms specified in this job.

description for the position I presently hold.

I further understand that this job description may be reviewed at any time and that I will be provided with a

revised copy.

_____ _____

Employee Signature Date

_____ _____

Agency Signature Date

COASTAL HEALTH CARE SYSTEMS INC.

TITLE OF POSITION: REGISTERED NURSE

TITLE OF IMMEDIATE SUPERVISOR: Supervising Nurse RISK OF EXPOSURE TO BLOODBORNE PATHOGENS – HIGH

DUTIES

To provide nursing care in accordance with the client's plan of care to include comprehensive health and psychosocial evaluation, monitoring of the client's condition, health promotion and prevention coordination of services, teaching and training activities and direct nursing care

RESPONSIBILITIES

1. Coordinates total client care by conducting comprehensive health and psychosocial evaluation, monitoring the client's condition, promoting sound preventive practices, coordinating services and teaching and training activities.
2. Evaluates the effectiveness of nursing service to the client and family on an ongoing basis.
3. Performs admission, transfer, re-certification, resumption of care and discharge paperwork for the home care client.
4. Prepares and presents client's record to the Clinical Record Review Committee as indicated.
5. Consults with the attending physician concerning alterations of Client Care Plans, checks with the appropriate supervisor, and makes changes, as appropriate.
6. Coordinates client services
7. Submits clinical notes no less often than weekly, and progress notes and other clinical record forms outlining the services rendered as indicated.
8. Submits a tally of client care visits made each day.
9. Participates in case conferences, discusses with the supervisor problems concerning the clients and how they may best be handled.
10. Discusses with the appropriate supervisor the need for the involvement of other members of the health team.
11. Obtains orders for paraprofessional service and submits a referral to the appropriate personnel.
12. Participates in the client's discharge planning process.
13. Cooperates with other agencies providing nursing or related services to provide continuity of care and to implement a comprehensive care plan.
14. Participates in staff development meeting.

15. Continually strives to improve his/her nursing care skills by attending in-service education, through formal education, attendance at workshops, conferences, active participation in professional and related organizations and individual research and reading.

16. Participates in the development and periodic revision of the physician's Plan of Treatment and processes change orders as needed.

17. Submits clinical notes within seventy-two (72) hours, and progress notes and other clinical record forms outlining the services rendered.
18. Participates in the client's discharge planning process.
19. Maintains an on-going knowledge of current drug therapy.
20. Adheres to Federal, state and accreditation requirements.
21. May be requested by Supervising Nurse to fill in for the other nurses.

COORDINATES THE ADMISSION OF A CLIENT TO THE AGENCY

1. Conducts an initial and ongoing comprehensive assessment of the client's needs at appropriate time frames.
2. Obtains a medical history from the client and/or a family member particularly as it relates to the present condition.
3. Conducts a physical examination of the client, including vital signs, physical assessment, mental status, appetite, and type of diet, etc.
4. Evaluates the client, family member(s) and home situation to determine what health teaching will be required.
5. Evaluates the client's environment to determine what assistance will be available from family members in caring for the client.
6. Evaluates the client's condition and home situation to determine if the services of a Home Health Aide will be required and the frequency of this service.
7. Explains nursing and other Agency services to clients and families as a part of planning for care.
8. Develops and implements the nursing care plan.
9. May be requested by the Supervising Nurse to fill in for other nurses who are on vacation or sick.

PROVIDES SKILLED NURSING CARE AS OUTLINED IN THE NURSING CARE PLAN

1. Nursing services, treatments and preventative procedures requiring substantial specialized skill and ordered by the physician.
2. The initiation of preventative and rehabilitative nursing procedures as appropriate for the client's care and safety

3. Observing signs and symptoms and reporting to the physician reactions to treatments, including drugs, as well as changes in the client's physical or emotional condition

4. Teaching, supervising, and counseling the client and caregivers regarding the nursing care needs and other related problems of the client at home.

ASSUMES RESPONIBILITY FOR THE CARE GIVEN BY THE HOME HEALTH AIDE

1. Supervises and evaluates the care given by the Home Health Aide as per agency policy.

2. Submits to the appropriate department/individual a written evaluation of the Home Health Aides who are providing service to the clients in his/her geographical area.

3. Participates in periodic conferences with the Home Health Aide supervisor concerning the Aide's performance.

4. Charts those services rendered to the client by the staff nurse and changes that have been noted in the client's condition and/or family and home situation, makes revisions in the nursing care plan as needed, records supervisory visits conducted with the Home Health Aide, evaluates client care and progress, and closes charts of discharged clients.

5. Evaluates the effectiveness of her nursing service to the individual and family.

6. Consults with the attending physician concerning alteration of the plan of treatment in consultation with the supervisor.

7. Submits clinical notes no less often than weekly, and progress notes and other clinical record forms outlining the services rendered as indicated.

8. Submits a tally of visits made each day.

9. Participates in case conferences.

10. Discusses with the supervisor problems concerning the clients and possible resolution.

11. Discusses with the supervisor the need for involvement of other members of the health team such as the home health aide, physical therapist, speech therapist, occupational therapist, social worker, etc.

12. Obtains orders for paraprofessional service and submits referral to appropriate personnel.

13. Provides guidance and supervision to the LVN and supervises the LVN per agency policy.

14. Coordinates total client care.

15. Cooperates with other agencies providing nursing or related services to provide continuity of care and to implement a comprehensive care plan.

16. Participates in staff development meetings.

17. Participates in the educational experiences for student nurses.

18. Continually strives to improve his/her nursing care by attending in-service education, through formal education, attendance at workshops, conferences, goal setting, active participation in professional and related organizations and individual research and reading.

19. Participates in the planning, operation, and evaluation of the nursing service.

20. Participates in the development and periodic revision of the physician's Plan of Treatment and processes change orders as needed.

21. Participates in the client's discharge planning.

22. Maintains an on-going knowledge of current drug therapy.

23. Prepares the care plan for the Home Health Aide

JOB CONDITIONS

1. Must have a driver's license and be willing and able to drive to client's residences.
2. The ability to access clients' homes, which may not be routinely wheelchair accessible, is required. Hearing, eyesight, and physical dexterity must be sufficient to perform a physical assessment of the client's condition and to perform and demonstrate client care.
3. Physical activities will include walking, sitting, stooping, and standing and minimal to maximum lifting of clients and the turning of clients.
4. The ability to communicate both verbally and in writing in English is required as frequent communication by telephone and in writing is involved.

EQUIPMENT OPERATION

Thermometer, B/P cuff, glucometer, penlight, hand washing materials.

COMPANY INFORMATION

Has access to all client medical records, personnel records and client financial accounts which may be discussed with the Supervising Nurse

QUALIFICATIONS

1. Must be a graduate from an accredited School of Nursing
2. Must be licensed in Texas as a Registered Nurse
3. One or more years of experience in a community/home health agency or in a hospital setting is preferred.
4. Must have a working knowledge of home health care and the principles and techniques of professional nursing and required documentation that pertains to it.
5. Should be skillful in organization and in the principles of time management and have knowledge of management processes.
6. Must be able to contribute to the quality of care being rendered through constructive communication with nursing managers and staff.
7. Must have a criminal background check.

8. Must have a current CPR certification.

ACKNOWLEDGMENT

Employee Signature	Date

COASTAL HEALTH CARE SYSTEMS INC.

Title of Position: Registered Nurse

Title of Immediate Supervisor: Supervising Nurse

Evaluation Scale:

1. **Excellent**
2. **Very Good**
3. **Average**
4. **Below Average**
5. **Poor**

PERSON BEING EVALUATED:					
EVALUATOR:					
RESPONSIBILITY/DUTY	**GRADE**				
1. Coordinates total client care	1	2	3	4	5
2. Evaluates the effectiveness of nursing service to the client and family	1	2	3	4	5
3. Prepares and presents client's record to the Clinical Record Review Committee as indicated	1	2	3	4	5
4. Consults with the attending physician concerning alterations of Client Care Plans, checks with the appropriate supervisor and makes changes, as appropriate	1	2	3	4	5
5. Submits clinical notes no less often than seventy-two (72) hours, and progress notes and other clinical record forms outlining the services rendered as indicated	1	2	3	4	5
6. Submits a tally of client care visits made each day	1	2	3	4	5
7. Participates in case conferences, discusses with the supervisor problems concerning the clients and how they may best be handled	1	2	3	4	5
8. Discusses with the appropriate supervisor the need for the involvement of other members of the health team such as the Home Health Aide, Physical Therapist, Speech Therapist, Occupational Therapist, Medical Social Worker, etc.	1	2	3	4	5
9. Obtains orders for paraprofessional service and submits a referral to the appropriate personnel	1	2	3	4	5
10. Participates in the client’s discharge planning process	1	2	3	4	5
11. Cooperates with other agencies providing nursing or related services to provide continuity of care and to	1	2	3	4	5

implement a comprehensive care plan					

12. Participates in staff development meeting	1	2	3	4	5
13. Continually strives to improve his/her nursing care skills by attending in-service education, through formal education, attendance at workshops, conferences, active participation in professional and related organizations and individual research and reading.	1	2	3	4	5
14. Participates in the development and periodic revision of the physician's Plan of Treatment and processes change orders as needed	1	2	3	4	5
15. Participates in the client's discharge planning process	1	2	3	4	5
16. Maintains an on-going knowledge of current drug therapy	1	2	3	4	5
Conducts the Admission of a Client to the Agency:					
1. Conducts an initial and ongoing comprehensive assessment of the client's needs at appropriate time points	1	2	3	4	5
2. Obtains a medical history, from the client and/or a family member particularly as it relates to the present condition	1	2	3	4	5
3. Conducts a physical examination of the client, including vital signs, physical assessment, mental status, appetite and type of diet, etc.	1	2	3	4	5
4. Evaluates the client, family member(s) and home situation to determine what health teaching will be required	1	2	3	4	5
5. Evaluates the client's environment to determine what assistance will be available from family members in caring for the client	1	2	3	4	5
6. Evaluates the client's condition and home situation to determine if the services of a Home Health Aide will be required and the frequency of this service	1	2	3	4	5
7. Explains nursing and other Agency services to clients and families as a part of planning for care	1	2	3	4	5
8. Develops and implements the nursing care plan	1	2	3	4	5
Provides Skilled Nursing Care as Outlined in the Nursing Care Plan to Include the Following:					
1. Nursing services, treatments, and preventative procedures requiring substantial specialized skill and ordered by the physician	1	2	3	4	5
2. The initiation of preventative and rehabilitative nursing procedures as appropriate for the client's care and safety	1	2	3	4	5
3. Observing signs and symptoms and reporting to the	1	2	3	4	5

physician reactions to treatments, including drugs, as					

well as changes in the client's physical or emotional condition					
4. Teaching, supervising, and counseling the client and caregivers regarding the nursing care needs and other related problems of the client at home	1	2	3	4	5
5. Supervises the LVN per agency policy	1	2	3	4	5
Assumes Responsibility for the Care Given by the Home Health Aide:					
1. Supervises and evaluates the care given by the Home Health Aide as needed, and per agency policy	1	2	3	4	5
2. Submits to the appropriate department/individual a written evaluations of the Home Health Aides who are providing service to the clients in his/her geographical area	1	2	3	4	5
3. Participates in periodic conferences with the Home Health Aide supervisor concerning the Aide's Performance	1	2	3	4	5
4. Charts those services rendered to the client by the staff nurse and changes noted in the client's condition and/or family and home situation, makes revisions in the nursing care plan as needed, records supervisory visits conducted with the Home Health Aide, evaluates client care and progress and close charts of discharged clients	1	2	3	4	5

GOAL SETTING:

ACKNOWLEDGEMENT

Employee Signature: Date:

Evaluator Signature:

Additional Comments

COASTAL HEALTH CARE SYSTEMS INC.

Skills Competency Evaluations

Skills Competency evaluations are performed to ensure that staff members that perform functions involving specific patient/client care tasks are competent in those areas and maintain proficiency. The results of skills competency evaluations also provide a means to measure the adequacy of an Agency's formal and informal training programs. Data will be collected continuously, aggregated, and analyzed for patterns and trends as part of the performance improvement program:

1. Before any field staff member may conduct an unsupervised patient visit, he or she must pass a skills competency evaluation.

2. Skills competency evaluations are next conducted on the one-year anniversary of employment and then annually.

3. In addition, skills competency evaluations are also required if in the judgment of the Governing Body there has been a significant change in the method of delivering services, dictated by either regulatory change or advances in technology.

4. The agency has developed Skills Competency Checklists for each professional and paraprofessional position.

5. Competency evaluations are conducted by the Agency for each directly hired staff member and any individual who is contracted by the Agency on an individual basis.

6. Skills competency evaluations are carried out by "LIKE" professionals that have appropriate supervisory experience:

    a. Registered Nurses (including the Director Nursing) will conduct skills competency evaluations for staff members that perform home health aide duties.

    b. Registered Nurses (to include the Director Nursing or equivalent) will conduct skills competency evaluations for LPNs.

    c. Registered Nurses (to include the Director Nursing or equivalent) will conduct skills competency evaluations for other registered nurses.

    d. The skills competency evaluation for the Director of Nursing (or equivalent) will be conducted by the Alternate.

    e. The skills competency evaluations for therapy assistant will be conducted by the appropriate licensed therapist.

    f. The skills competency evaluations for licensed therapist will be conducted by another therapist holding the same license. (Medical Social Workers and Nutritionists, if utilized will similarly be responsible with similarly have their competency evaluations conducted by like professionals).

COASTAL HEALTH CARE SYSTEMS INC.

Methods of Determining Competence and Skill Level

1. Clinical skills must be observed by a manager or designee, who based on his/her clinical and managerial knowledge, experience, and history of competence and proficiency, is qualified to evaluate skill proficiency.

2. Simulated testing stations/lab settings may be used to determine ability to perform a skill. Skills testing is to be done on patients or 'pseudo-patients'. Staff will not use mannequins.

3. Learning and training are distinct from proficiency. The Agency will need to determine if a clinician is skilled after one observed experience. The choice of lab setting vs. observing a skill performed in the home must be driven by the type of skill.

4. A skill which is cognitive can be evaluated through written exam and oral presentation. Any skill which is technical must be observed.

Competencies Not Met

1. If a field staff member is observed and evaluated not to be proficient or competent in a skill, an action plan with defined time parameters, and a schedule set for re-observation will be implemented.

2. Staff members that are unable to meet competency requirements are not permitted to perform those tasks until they can demonstrate competency.

3. All core and specialty competency requirements must be successfully completed to receive a satisfactory performance appraisal and rating.

PLEASE UTILIZE THE FORMS BELOW TO CONDUCT SKILLED COMPETENCY EVALUATIONS FOR ALL APPROPRIATE STAFF THAT YOU EMPLOY OF CONTRACT WITH ON A ONE-TO-ONE BASIS. COMPETENCIES CONDUCTED AT HIRE AND THEN ON AN ANNUAL BASIS ARE TO BE SIGNED BY THE EMPLOYEE AND THE EVALUATOR AND INSERTED INTO SECTION 3 OF THE EMPLOYEES FILE.

COASTAL HEALTH CARE SYSTEMS INC.

FOR REGISTERED NURSES

Employee name: _____

SCALE	E-EXCELLENT	G-GOOD	F-FAIR	P-POOR

SKILLS ASSESSED BY OBSERVATION OF ACTUAL PERFORMANCE	COMPETENCY ASSESSMENT CONDUCTED BY A COMPETENCY VALIDATED REGISTERED NURSE				AREAS NEEDING IMPROVEMENT **Employee may not perform task independently until competency established
Task	E int / Date Assessed	G int / Date Assessed	F int / Date Assessed	P int / Date Assessed	
System Assessments:					
Temperature					
Pulse-Radial and Apical					
Respirations					
Blood Pressure					
Pulse Oximetry					
Weight					
Respiratory					
Cardiovascular					
Digestive/Gastrointestinal					
Endocrine					
Nutrition					
Neurological/Emotional					
Pain					
Musculoskeletal					
Sensory					
Functional Limitations					
Ears/Nose/Throat/Eyes					
Integumentary					
Teaching:					
Disease process					

Diet/Nutrition

Medication

Diabetic Management

COASTAL HEALTH CARE SYSTEMS INC.

Wound Care:					
Sterile					
Non-sterile					
Wound vac					
Wound measuring					
Patient care:					
Venipuncture/Lab Draws					
Specimen collection					
Catheter Care					
Foley Insertion					
Replace Suprapubic					
Care of G-tube					
Blood Glucometer use					
Care of JP drain					
Suture removal					
Staple removal					
Incentive Spirometry					
Colostomy care					
Ileostomy care					
Ileal conduit care					
Cast care					
Use of splints					
Safe transfer techniques					
Use of assistive devices:					
Walker					
Wheelchair					
Medication Administration:					
Oral					
Intramuscular					
Subcutaneous					

Eye drops

Ear drops

Nose drops

Enteral feedings

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Inhaled medications					
Oxygen therapy					
Nebulizer therapy					
Infection control:					
Universal Precautions					
Hand Washing					
Bag Technique					
Glove use					
Biohazard waste					
Sharps disposal					
Specimen transport					
Documentation:					
Admission paperwork					
Care Plan development					
Visit notes					
Supervisory visits:					
LPN					
CNA					
CMT					

Employee Name	Signature	Date
Evaluator	Signature	Date

Comments:

COASTAL HEALTH CARE SYSTEMS INC.

Inservice Post Test

Employee Name: _____

Date: _____

Score: _____

1. Cultural differences are not limited to ethnicity and race relations; they extend to areas of religious views, sexuality and even differences in geographical differences pertaining to the location of one's upbringing.

    a. True

    b. False

2. Where an employee lives or has lived can contribute to cultural differences in the workplace.
    a. True

    b. False

3. What federal agency prohibits companies from discriminating against employees for any reason?

    a. OSHA

    b. CMS

    c. U.S. Equal Employment Opportunity Commission

    d. All of the above

4. The agency is not required to transport or physically evacuate a patient in the event of an emergency.

    a. True

    b. False

5. The patient is provided with the following:

    a. A copy of the Agency's policy on how to handle disaster-related emergencies in the home.

    b. Patient responsibilities in the Agency's Emergency Preparedness and Response Plan.

    c. A list of community disaster resources that can assist during a disaster-related emergency.

    d. All of the above.

6. The agency reviews the Emergency Disaster Plan as:

    a. Needed.

    b. At least yearly.

    c. After each response.

    d. All of the above.

7. What are the types of emergencies?

    a. Man-Made.

b. Natural.

c. Technological.

d. Any of the above.

8. All patients are informed of their right to voice a complaint/grievance against anyone furnishing services on behalf of the agency at:
   a. On admission.

   b. Before admission.

   c. A and B.

   d. None of the above.

9. What is the timeframe to provide the patient a response to the complaint?

   a. 10 days.

   b. 3 days.

   c. 30 days.

   d. As soon as possible.

10. How often are complaints reported to the Governing Body?
    a. Monthly
    b. Weekly
    c. Quarterly
    d. B and C
11. Who serves as the Agency's Privacy Officer?
    a. Director of Nursing
    b. Governing Body
    c. Administrator
    d. CFO
12. What does HIPAA stand for?
    a. Health Information Privacy Administrative Act
    b. Health Insurance Portability Accountability Act
    c. Health Information Protected and Accessed
13. What is the most important task performed to protect against infections?
    a. Using gloves.
    b. Good handwashing.
    c. Covering mouth when coughing.
    d. Staying home when you are sick.
14. Patient care bags may be put on the floor if a barrier is used?
    a. True
    b. False
15. Areas and equipment contaminated with blood should be cleaned immediately with:
    a. Lysol wipe.
    b. 1:10 bleach solution (10%).
    c. 100% bleach.
    d. Blood should not be touched.
16. Successful communication requires knowing what barriers to communication exist and how to navigate around those roadblocks. These may include:
    a. Physical barriers.
    b. Language barriers.
    c. Gender barriers.

d. Any of the above.

17. Non-verbal communication components can include physical appearance.

    a. True

    b. False

18. SDS

    a. Is the new acronym for MSDS.

    b. Means “Service Date Same”.

    c. Will give symptoms for diseases.

    d. Stands for Safety Data Sheets.

19. OSHA was created to:

    a. Enforce local and state regulations.

    b. To require employers to assure a safe and healthful workplace.

    c. Provide a place to buy protective equipment.

    d. As a “catch all” for employee complaints, in general.

20. If a death of an employee occurs while working, how many hours does the agency have to notify OSHA?

    a. 10

    b. 8

    c. 24

    d. 48

21. Key items to remember about the Patient Bill of Rights are:

    a. The rights can be exercised at anytime.

    b. The patient always has the right to refuse care.

    c. The patient has the right to be treated with respect.

    d. All of the above.

22. A Corporate Compliance program is a system which is designed to detect and prevent violations of law by the agents, employees, officers and directors of a business.

    a. True

    b. False

23. What are the potential penalties the agency may face for non-compliance?
    a. prison
    b. fines
    c. sanctions
    d. possibly all of the above
24. The Code of Ethics is intended to serve as a guideline to the agency in the following areas:
    a. Patient Rights and Responsibilities
    b. Relationships to Other Provider Agencies
    c. Fiscal Responsibilities
    d. Marketing and Public Relations
    e. Personnel
    f. All of the above
25. Ethical issues for employees include:
    a. Working or traveling on certain religious holidays
    b. Right to life issues
    c. Administering blood transfusions
    d. Respecting an individual decision not to seek medical care because of their religious beliefs
    e. All of the above
26. Blood borne pathogens are infectious microorganisms in human blood that can cause disease in humans.
    a. True
    b. False

27. OSHA requires that a hepatitis B vaccination series to be made available to all employees who have occupational exposure within 10 working days of initial assignment.
    a. True
    b. False

28. How often does CDC recommend TB skin testing for direct care employees?
    a. On hire
    b. Yearly
    c. Exposure
    d. Every 3 years
    e. A, B and C

29. An equipment malfunction is reportable if the following occurs:
    a. Likely to cause a death.

b. Likely to cause a serious injury.
c. Contributes to a death or serious injury.
d. All of the above.

30. Which of the following are considered reportable?
    a. Prescription or over-the-counter medicines
    b. Biologics
    c. Medical Devices
    d. All of the above

COASTAL HEALTH CARE SYSTEMS INC.

Answer Key for Comprehensive In-service Training Module

1. A
2. A
3. C
4. A
5. D
6. D
7. D
8. C
9. A
10. C
11. C
12. B
13. B
14. B
15. B
16. D
17. A
18. D
19. B
20. B
21. D
22. A
23. D
24. F

25. E

Additional questions for Direct Caregivers

26. T

27. T

28. E

29. D

30. D

COASTAL HEALTH CARE SYSTEMS INC.

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

It is both the Agency's and the employee's responsibility to ensure that every patient's health information is always protected. By signing below, you are indicating the acknowledgement of HIPAA and understand that a thorough orientation of the agency's policy regarding patient's Protected Health Information will be provided to you upon hire.
I understand that I may be handling Protected Health Information. I further understand that there are specific guidelines associated with the use and disclosure of Protected Health Information. I agree to protect the Electronic Record and passwords provided to me as outlined in the HIPAA policy.

The agency has sanctions and fines for all individuals failing to comply with HIPAA Rule and Regulations.

Employee: _____ Date: _____

PROTECTION OF HEALTH INFORMATION

There are specific guidelines to ensure a patient's Protected Health Information is kept private. I understand that my employment with the agency involves handling Protected Health Information. I will ensure patient's records are protected by enforcing the following measures:

- Patient Protected Health Information will be transported in a protected travel chart when traveling.
- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it is conducted in a private area.
- Patient Protected Health Information will be returned to the agency upon acknowledgement of the patient being discharged.

I pledge to make every effort to keep patient's Protected Health Information always protected.

Employee_____

Date: _____

COASTAL HEALTH CARE SYSTEMS INC.

ELECTRONIC DOCUMENTATION AND SIGNATURE AUTHENTICITY AGREEMENT

I understand that Agency staff may use electronic signatures on all computer-generated documentation. An electronic signature will serve as authentication on patient record documents and other agency documents generated in the electronic system.

For the purpose of the computerized medical record and other documentation for agency purposes, I acknowledge my use of the Signature Passcode and my Login authentication password will serve as my legal signature. I further understand that the Administrator issues employee passwords and the Signature Passcode's are issued by the software application.

Signature Passcodes and passwords will be changed on an as needed basis if system security is breached. I understand that prior to exporting documentation to the agency server, I am required to review and authenticate, by use of electronic signature, my documentation on the field-based or office computer. (OASIS Comprehensive Assessments will not require electronic signature until required information is obtained, which may be up to five days after the corresponding MO date i.e.: MOO30, MOO32 etc.) I understand that: I cannot divulge my login password, Signature Passcode, I must exit the computerized application at the end of each working day or whenever the computer is not in my immediate possession, I must type in (rather than save) the login password that allows me access to the agency computer network, and my Signature Passcode. I must review all of my documentation online prior to submitting it to the agency server.

_____ _____ Date

Employee Signature

_____ _____ Date

Witness Signature

COASTAL HEALTH CARE SYSTEMS INC.

Signature Attestation

The Signature Attestation statement identifies the author associated with initials or illegible signature.

The signature of physicians and staff who document on patient charts will then be able to be identified as per federal, state and accreditation requirements.

Date _____

I do hereby attest that this information and the signature below is mine, true, accurate, and complete.

Full Printed Name with Credentials _____

Signature as used in medical records _____

Alternate forms of signature or initials used in records

_____

_____

_____

_____

COASTAL HEALTH CARE SYSTEMS INC.

FIELD EMPLOYEE STANDARDS AND PROCEDURES

This Agency requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the patient/family. This includes personal hygiene, jewelry, hair and makeup.

2. **Please do not smoke in the presence of a patient.**

3. Always wear your ID Badge.

4. You are expected to arrive on time to all assignment that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more, or to be totally absent from the assignment you must notify the Agency immediately. PLEASE DO NOT CALL YOUR PATIENT DIRECTLY. You may call the Agency 24 hours a day if you need to cancel or reschedule your assignment. **A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!**

5. If you have any problem, incident or accident on the job, do not discuss it with the patient, but call the Agency immediately.

6. If the patient asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.

7. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they **WILL NOT, UNDER ANY CONDITIONS, DISPENSE OR ADMINISTER ANY MEDICATION.**

8. UNDER NO CIRCUMSTANCES are you to ask for, or accept any money from your patient or take home property that belongs to the patient.

9. There shall not be any involvement with the patient's financial affairs (i.e. check writing).

10. You are expected to honor the confidentiality of any patient information which is obtained in the regular course of your employment.

11. No personal telephone calls should be made or received by you while on assignment.

12. Please do not discuss your pay or any other personal affairs with the patient/family.

13. As an employee of this Agency, you are not authorized to accept any direct employment that may be offered to you by your patient/client/family. If you are requested to do so, please have the patient contact us.

14. **It is imperative that all signed notes and documentation, including Daily Log, be filled out properly and returned to the office as per our schedule**. If the patient is unable to sign your note, a family member or responsible party may sign.

15. During the course of employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.

Employee Signature_____ Date_____

COASTAL HEALTH CARE SYSTEMS INC.

CONFIDENTIALITY AND NON-COMPETITION AGREEMENT

The Agency requires that the Employee avoid disclosure of confidential information to anyone outside of the Agency and refrain from engaging in unfair competition.

The Employee agrees to refrain from prohibited competition with the Agency and to maintain the confidentiality of information regarding employees, clients and the Agency business.

The Employee will have access to information not generally made available to the public, such as identity of clients, pricing, computer-related programs, etc. The Agency prohibits the utilization of this information for any purposes other than for the Agency's own benefit and prohibits disclosure or unauthorized use during the course of employment or at any time thereafter of any confidential information pertaining to Agency administration and/or projects, or outside investigations of the Agency. The employee is prohibited from disclosing any defaming information regarding Agency personnel and/or personnel incidents related to any violations of the personnel policies.

During the course of employment and for a twelve month period thereafter the Employee is prohibited from engaging in any of the following: induce any employee of the Agency to resign, encourage any client or entity to discontinue any relationship with the Agency, solicit any client of the Agency (current and within the past twelve month period), enter into competitive employment or seek to provide competitive services while employed within twenty-five miles of any office of the Agency, or solicit referrals or opportunities from any referral source.

Upon termination of employment or at the request of the Agency, the Employee is required to return all of the Agency's property including keys, ID badge, client records, forms, manual, beeper, etc. to the Agency and will not retain copies.

Violation of this agreement will result in termination and any additional remedy available to the Agency including legal action to remedy all damages including loss of profits, cost of replacing and training employees improperly solicited for competitive employment, etc. suffered by the Agency. Employee will be required to reimburse the Agency for all legal fees, costs and other expenses.

This agreement is in effect during the Employee's employment and for twelve months thereafter. It does not modify the right of the Employee to resign at any time or of the Agency to terminate employment without prior cause, notice or liability and does not modify any other Agency policy.

_____ _____

Employee Date

COASTAL HEALTH CARE SYSTEMS INC.

CONFIDENTIALITY OF CLIENT INFORMATION

By accepting employment with COASTAL HEALTHCARE SYSTEMS INC Agency, I agree to carefully refrain from discussing any client's condition or personal affairs with anyone outside the agency, unless expressly authorized 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 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 breach of professional ethics, but can also involve an employee in legal proceedings. I will not share any Information about clients or the agency with the media. This is essential for protection of both the client and Agency. I, further, understand that at no time am I to allow a client to endorse a check over to the home care agency or myself.

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 from employment.

_____

Employee Signature Date

_____

Witness Signature Date

COASTAL HEALTH CARE SYSTEMS INC.

HIPAA CONFIDENTIALITY AGREEMENT

CONFIDENTIALITY AGREEMENT OF CLIENT HEALTH INFORMATION AND PERSONAL INFORMATION IN ACCORDANCE WITH HIPAA REGULATIONS

For good consideration and as an inducement for COASTAL HEALTH CARE SYSTEMS INC, (employer) to employ _____ (employee), the undersigned Employee hereby agrees not to directly or indirectly use, manipulate or copy compete any client health information (PHI), to include personal health information or personal contact information (address, phone, email address, etc.) with the business of the Agency and its successors and assigns during the period of employment. Misuse of PHI or personal contact information will result in termination and report with action to HIPAA federal agencies. Fines related to civil and criminal offences for gross misconduct with the above information are the direct responsibility of said employee.

The Employee acknowledges that the Agency shall or may in reliance of this agreement provide Employee access to trade secrets, customers and other confidential data and good will. Employee agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose same to any third party or for their own personal or monetary gain.

The Employee understands that in no circumstances are they to agree to assume power of attorney or guardianship over a client utilizing the Agency's services. In addition, it is understood that they are prohibited from allowing a consumer to endorse a check over to the home care agency or themselves.

The Employee agrees to not copy and to return all such Agency supplied Information immediately upon termination of employment. Further employee agrees not to solicit any of the customers or employees of employer for any purpose for a period of two years after termination.

This agreement shall be binding upon and inure to the benefit of the parties, their successors, assigns, and personal representatives.

Signed this _____ day of _____ 20____

_____

Agency

_____

COASTAL HEALTH CARE SYSTEMS INC.

Employee

COASTAL HEALTH CARE SYSTEMS INC.

COMPLIANCE STATEMENT

The Corporate Compliance Statement provided below is to be acknowledged and signed by every Agency employee as well as every employee working for the Agency on a contract basis.

~~CORPORATE COMPLIANCE POLICY~~
Acknowledgment of Receipt and Understanding
As you know, our Home Care Agency and our Staff members have always been committed to providing exceptional health care and upholding ethical conduct standards and legal compliance.
Our policy formally and clearly states that there is zero tolerance to any form of fraud or misconduct. This Agency believes that every employee or agent plays a key and active role in maintaining its image and reputation.
I hereby acknowledge that I have been apprised of and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.
Employee's printed name:
Employee's signature and date:

COASTAL HEALTH CARE SYSTEMS INC.

EMPLOYEE POLICIES AND PROCEDURES

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, understand and conform to all applicable Agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Agency's Policy and Procedure on Abuse, Neglect and Exploitation and agree to Comply with and be bound by the Policy.
I understand that information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees, nor is it an expression of my term of employment.

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force on any vehicle I use for the conduction of Agency business during the term of my employment. The Agency has the right to request proof of insurance at any time during the term of employment and I am required to follow all Agency requirements and state and local laws.

I understand that only the Agency has the authority to admit clients and will supervise with appropriate personnel all services provided.

As a caregiver, I will carry out the plan of treatment, submit time sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans of care, periodic client evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend the required staff meeting and inservice training. Home health aides are required to have 12 hours of inservice training annually.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided. I understand that all information, both written and verbal, regarding client and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease; testing, results or known infection by HIV, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alcohol abuse is protected under specific law. All information in connection with the examination, care or provision of services to any client will not be disclosed without the individual's written consent except as may be necessary to provide services as required by law. Information may be used in statistical or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of client/ employee confidentiality is subject to civil and criminal penalties.

If I mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize the Agency to deduct any amount from my paycheck(s) to correct my accrued or earned sick or vacation leave balance. I understand that this company does not routinely perform drug testing on its employees but may do so at its discretion. I understand that this company is an "At Will" organization and may hire and fire at will.

Employee Signature_____ Date _____

COASTAL HEALTH CARE SYSTEMS INC.

PERSONAL PROTECTIVE EQUIPMENT FOR SAFETY AND INFECTION CONTROL ACKNOWLEDGMENT

I understand a Personal Protective Equipment (PPE Kit) is available in the office and contains the following:

- Barrier Safety Goggles
- CPR Shield Face Barrier
- Fluid Resistant Gown
- Gloves
- Biohazard Bag
- Sharps Container
- 3M Respirator Mask (N95 or similar purchased from Uline.com)

I have been instructed in the use of this equipment and understand that I must comply with Policies and Procedures regarding use of personal protective equipment.

Signature/Title_____ Date_____

COASTAL HEALTH CARE SYSTEMS INC.

HEALTH STATEMENT

Applicant Name: _____Date_____ _____

I, _____ hereby attest that the state of my health is such that it will enable me to perform the duties of a health care professional. I further specifically attest that I am free of any and all potentially contagious diseases including, but not limited to those listed below:

AIDS	Anthrax	Chickenpox	Cholera
Diphtheria	Encephalitis	Hepatitis, Types A, B and C	Influenza
Leprosy (Hansen's Disease)	Leptospirosis	Malaria	Measles (Rubeola)
Meningitis	Mononucleosis	Mumps	Whooping Cough
Plague	Poliomyelitis	Psittacosis (Ornithosis)	Rabies
Rocky Mountain Spotted Fever	Rubella (German Measles)	Shigellosis	Smallpox
Tetanus	Tularemia	Tuberculosis	Typhoid Fever

COASTAL HEALTH CARE SYSTEMS INC.

HEPATITIS VACCINE REQUIREMENT

I _____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

- ☐ Request that I receive the Hepatitis vaccine

- ☐ Refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

- ☐ Provide written proof of immunity (attach)

- ☐ Provide written proof of previous vaccination (attach)

- ☐ Provide written proof of medical contraindication (attach)

Signature: _____ Date: _____

COASTAL HEALTH CARE SYSTEMS INC.

TB TARGETED MEDICAL QUESTIONNAIRE FORM

To be completed by employee:

_____

Print Name

		YES	NO
1.	Have you ever had a positive TB skin test or history of TB infection?	____	____
	If the answer is YES, please answer the following:		
2.	Have you ever had the BCG vaccine?	____	____
3.	Do you have prolonged or recurrent fever?	____	____
4.	Have you recently lost weight?	____	____
5.	Do you have a chronic cough?	____	____
6.	Do you cough up blood?	____	____
7.	Do you have sweating at night?	____	____

8. Do you have any of the following risk factors which may substantially Increase the risk of tuberculosis?

____ a. Silicosis (Lung Disease)
____ b. Gastrectomy
____ c. Intestinal Bypass
____ d. Weight 10% or more below ideal body weight?
____ e. Chronic Renal Disease
____ f. Diabetes Mellitus
____ g. Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy
____ h. Hematologic Disorder 1.e. leukemia or lymphoma
____ i. Exposure to HIV or AIDS
____ j. Other malignancies

_____ _____

Employee Signature Date

COASTAL HEALTH CARE SYSTEMS INC.

COASTAL HEALTH CARE SYSTEMS INC.

RECEIPT OF EMPLOYEE HANDBOOK

This is to acknowledge that I have received a copy of the Agency Employee Handbook and understand that it sets forth the terms and conditions of my employment as well as the duties, responsibilities, and obligations of employment with the company. I understand and agree that it is my responsibility to read the Employee Handbook and abide by the rules, policies, and standards set forth in the Employee Handbook.

I acknowledge that my employment with the Agency is not for a specified period of time and I can be terminated at any time for any reason, with or without cause or notice, by me or by the company. I acknowledge that no oral or written statements or representations regarding my employment can alter the foregoing. I also acknowledge that no employee has the authority to enter into an employment agreement-express or implied-providing for employment other than at-will.

I acknowledge that except for the policy of at-will employment, the company reserves the right to revise, delete, and add to the provisions of this Employee Handbook. All such revisions, deletions, or additions must be in writing and must be signed by the President of the company. No oral statements or representations can change the provisions of this Employee Handbook. I also acknowledge that, except for the policy of at-will employment, terms and conditions of employment with the company may be modified at the sole discretion of the company with or without cause or notice at any time. No implied contract concerning any employment-related decision, term of employment, or condition of employment can be established by any other statement, conduct, policy, or practice.

I understand that the foregoing agreement concerning my at-will employment status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and our Agency concerning the duration of my employment, the circumstances under which my employment may be terminated, and the circumstances under which the terms and conditions of my employment may change. I further understand that this agreement supersedes all prior agreements, understandings, and representations concerning my employment with the company.

If I have questions regarding the content or interpretation of this handbook, I will bring them to the attention of my supervisor.

NAME_____

DATE_____

COASTAL HEALTH CARE SYSTEMS INC.

EMPLOYEE SIGNATURE_____

Original: Personnel file cc: Employee

COASTAL HEALTH CARE SYSTEMS INC.

AGREEMENT FOR NURSING SERVICES

THIS AGREEMENT made effective __/__/202__ Coastal health care systems inc, hereinafter referred to as "AGENCY", and represented by, Samuel Inegbedion its Administrator, and

_____, RN hereinafter referred to as "BUSINESS ASSOCIATE" or "NURSE".

1. **PURPOSE**

The purpose of this Agreement is to include additional staff to provide skilled nursing services to AGENCY's patients. These services are hereinafter referred to as "Skilled Nursing Services".

2. **ADMISSION OF PATIENTS AND SCHEDULING**

Patients eligible to receive Skilled Nursing from Nurse the terms of this Agreement shall only be such patients as are accepted and admitted for home health care services by the AGENCY.

NURSE shall not have any authority to admit patients.

The schedule of visits and the location for performing such services shall be agreed upon by the BUSINESS ASSOCIATE, patient, and the AGENCY.

3. **DUTIES OF THE BUSINESS ASSOCIATE**

Nurse, shall perform duties including, but not limited to, the following:

A. If the Nurse is an RN, she/he will perform thorough assessments of patient's abilities and limitations, initially and within five days of referral by AGENCY and assume ongoing supervision of therapy staff by appropriate professional personnel per agency's policies.

B. Provide services within the scope set forth in the physician's approved plan of treatment and ensure that services provided are in compliance with Medicaid, insurance and all local, state and federal requirements. Any alteration in the plan of treatment will originate from the patient's physician in coordination with the NURSE and the appropriate personnel of the AGENCY.

C. Observe, record and report to the AGENCY's Case Manager the patient's response to treatment and/or any changes in the patient's condition as well as participate in case conferences as required by the agency.

D. Maintain records and reports in accordance with the policy of the AGENCY, including visit reports and observations on the progress of the patient. Make available all relevant records and information applicable to each patient to be

treated by Nurse. All such records, including information and notes added by the nurse whose services are provided by the Nurse shall be property of the AGENCY.

E. Instruct other health team personnel including, when appropriate, Home Health Aides and family/caregivers in procedures which Nurse deems appropriate for the home health aide or family/caregiver to deliver. Such instructions will be documented in the nurse's progress notes.

F. Instruct the patient and/or family/caregivers on the goals, procedures, benefits and risks of services provided and solicit patient and/or family/caregiver participation in the plan of care.

G. Participate in Performance Improvement activities of the Agency.

H. Be involved in the discharge planning for each client to whom they provide service and will begin preparing the patient for discharge upon initial evaluation. Discharge instructions will be documented in the progress notes.

I. Submit clinical documentation, on Agency approved forms, with the invoice for these services on a weekly basis, by mail on Wednesday of the following week of service unless otherwise arranged. The week shall be considered as the period starting on Sunday and ending on Saturday.

J. Adhere to the Civil Rights Act of 1964.
K. Adhere to the Social Security Act section 1861(w).

4. **PERSONNEL QUALIFICATIONS**

Each Nurse providing services to a patient of the AGENCY will be appropriately licensed in the State of Texas, and will adhere to the policies and procedures of the

AGENCY.

A. NURSE, prior to the commencement of this agreement will provide The AGENCY with verification of licensing, educational and training requirements.

B. NURSE will provide THE AGENCY with evidence of current licenses, certifications, or registration.

C. NURSE will have and maintain appropriate clinical knowledge and experience to provide the level of care necessary to accomplish physician’s order and plans of care for assigned patients.

D. NURSE will ensure that he/she will, at a minimum, meet the requirements outlined in the job description provided by the AGENCY.

E. NURSE will have an ongoing process to insure that the competence of all staff members is assessed, maintained, and improved on a continuous basis.

F. NURSE will train care staff on all areas covered in the orientation program provided by the AGENCY and will maintain ongoing in-service education to meet AGENCY requirements.

G. NURSE will be free of communicable disease, oriented to infection control procedures, OSHA Blood Borne Pathogens Standards, home health safety procedures and confidentiality of patient information, and trained in patient/caregiver education related to nursing. Documentation in support of these requirements will be made available to the AGENCY.

5. **DUTIES OF THE AGENCY**

AGENCY will admit patients/clients and coordinate, supervise, and evaluate all home health services provided to patients/clients to verify that these services meet AGENCY's quality assurance standards.

AGENCY will supply NURSE with appropriate forms for documentation of patient/client assessments, services rendered, progress reports and any other documentation required by the AGENCY. AGENCY will allow NURSE to use its own forms if AGENCY reviews such forms and finds that they meet all AGENCY's requirements.

AGENCY will provide, maintain and make available for review patient/client's medical records to BUSINESS ASSOCIATE's nurses as is deemed necessary for delivery of nursing services.

AGENCY will not discriminate in employment or provision of services with respect to age, race, color, religion, military status, gender preference, sex, marital status, national origin, disability or source of payment.

AGENCY will communicate clinical and personnel concerns to the BUSINESS ASSOCIATE.

AGENCY, through ongoing interaction with client's and/or caregivers, will ascertain client satisfaction, progress or lack of, and any need for correction action related to ancillary services.

AGENCY will pay NURSE the amount for services rendered, as stated in the invoices, within fifteen (15) days of invoice date.

AGENCY agrees to the rates as set forth in Appendix A including the assessment of any interest charges as outlined for invoices that remain unpaid beyond the due date.

6. **HIPAA CONFIDENTIALITY**

NURSE agrees to comply with the applicable provisions of the Administrative Simplification section of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as codified at 42 U.S.C. 1230d through d-8, and the requirements of

any regulations promulgated there under including without limitation the federal privacy regulations as contained in CFR Part 164 (the "Federal Privacy Regulations")

and the federal security standards as contained in 45 CFR Part 142 (the "Federal Security Regulations").

NURSE agrees not to use or disclose any protected health information, as defend in 45 CFR 164.504, or individually identifiable health information, as defined in 45 U.S.C 1230d (collectively, the "Protected Health Information"), regulations promulgated under HIPAA including without limitation the Federal Privacy Regulations and the Federal Security Regulations.

NURSE agrees to implement appropriate safeguards to prevent the use or disclosure of a patient's Protected Health Information other than as provided for by this Agreement.

NURSE agrees that the terms of this Agreement shall be kept confidential. In addition, NURSE agrees not to disclose any of the AGENCY's proprietary information to any other party, including AGENCY's competitors, without AGENCY's written consent. This understanding shall survive the termination of this Agreement.

NURSE agrees to use protected health information only for the purpose of fulfilling the service requirements of this Agreement.

NURSE agrees to prohibit the use or disclosure of protected health information in any way that would violate current privacy standards;

NURSE agrees to establish appropriate safeguards to prevent the use or disclosure of protected health information stored or maintained by NURSE whether in written or electronic form.

NURSE agrees to report any misuse or disclosure of protected health information to the AGENCY and to the affected patient(s) within twenty-four (24) hours of discovering such misuse or disclosure.

NURSE agrees to provide a written procedure to AGENCY under which patients who are subjects of the protected health information may inspect and copy their information in possession of NURSE and allowing for the correction and amendment of information upon notice thereof from AGENCY;

NURSE agrees to provide a written procedure to AGENCY under which patients will be notified of the release of protected health information as required by current HIPAA regulation; and

NURSE agrees that upon expiration of this Agreement, NURSE shall return or destroy all protected health information received from AGENCY during the term of this Agreement, whether written or electronic format, and to retain no copies of such information.

This shall not preclude NURSE from maintaining sufficient information solely to permit timely billing and to meet record retention requirements, provided that such information is returned or destroyed once such billing or record retention requirements

are met and provided that the protections of HIPAA and this Agreement are extended until such time as such information is returned or destroyed.

7. **EMPLOYMENT RELATIONSHIP**

Nurse provided is self-employed and shall not be considered the employees of the Agency. As such AGENCY has no obligation to pay or withhold income tax, FICA or FUTA on behalf of the BUSINESS ASSOCIATE. NURSE will not take any action inconsistent with this position. NURSE agrees to hold AGENCY harmless of any and all taxes, penalties, FICA or FUTA which it may owe.

8. **PROFESSIONAL LIABILITY INSURANCE**

The NURSE shall keep in full force, for the duration of this contract, General Liability as well as Professional Liability with minimum limits of $1,000,000.00 or what is customarily acceptable at the AGENCY's discretion.

NURSE shall furnish to Agency a valid certificate of insurance evidencing that it has professional liability insurance coverage within limits that are customary for the services provided and acceptable at the Agency's discretion.

THE AGENCY may choose to cover NURSE under its insurance policy, in which case the two previous paragraphs do not apply.

9. **INDEMNIFICATION OF AGENCY**

NURSE agrees to indemnify and hold Agency and its officers, agents, and employees harmless, for any and all liability loss, damage, claim, or expense of any kind, including costs and attorney's fees, that result from negligent or willful acts or omissions by NURSE or its officers, agents, employees, in connection with the duties and obligations of NURSE under this Agreement.

10. **TERM, RENEWAL, AND TERMINATIONS**

The initial term of this Agreement shall commence at the date set forth as written above, and shall terminate upon the expiration of one (1) year thereafter. Agreement shall be renewed automatically for successive one (1) year terms, after review by Agency and BUSINESS ASSOCIATE, unless one of the parties notifies the other party in writing, of its intention not to renew the Agreement not less than thirty (30) days prior to any anniversary date. This Agreement may be terminated by Agency or NURSE by giving thirty (30) days written notice to the other party, any time during the term of the Agreement.

11. **ENTIRE AGREEMENT**

This Agreement and the schedules, exhibits, and the attachments hereto constitute the entire agreement between the parties hereto with respect to the subject matter hereof.

12. **SIGNIFICANCE OF HEADINGS**

Headings in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

13. **NOTICE**

Any notice required or permitted under terms of this Agreement shall be in writing and deemed to have been duly given as of the date given in person, or of deposit with the United States Postal Service or a courier service, by Certified or Registered mail, postage prepaid, return receipt requested, and addressed to the other party at its postal address as stated below.

IF IT IS ULTIMATELY DETERMINED AS A RESULT OF PUBLICATION OF THE REGULATION THAT SECTION 952 OF THE RECONCILIATION ACT OF 1980 (PUB. L. 96-499) APPLIES TO THIS CONTRACT, NURSE WILL MAKE ITS BOOKS AND RECORDS AVAILABLE TO AGENTS OF THE SECRETARY OF HEALTH AND HUMAN SERVICES OR THE COMPTROLLER GENERAL UPON REQUEST. THESE BOOKS AND RECORDS WILL BE MAINTAINED FOR CONTINUED ACCESS FOR A PERIOD OF FOUR YEARS AFTER SERVICES ARE RENDERED.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed as of the day and date first above written.

NURSE

Name: _____

Address: _____

Phone: _____

_____ _____

Nurse Date

AGENCY

Name: Coastal Health Care Systems Inc.

Address: 23527 Baker Hill Dr, Richmond TX 77469

Phone: (832) 603-3773, 832-275-0994
Fax: 1-888-711-2314
Email coastalhealthcaresystems@yahoo.com

_____

Samuel Inegbedion Administrator

COASTAL HEALTH CARE SYSTEMS INC.

Date

COASTAL HEALTH CARE SYSTEMS INC.

Employment Eligibility Verification

USCIS

Department of Homeland Security

U.S. Citizenship and Immigration Services

Form I-9

OMB No. 1615-0047

Expires 10/31/2022

►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: _____

COASTAL HEALTH CARE SYSTEMS INC.

e r : C o u n t r y o f I s s u a n c e :

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

COASTAL HEALTH CARE SYSTEMS INC.

Employment Eligibility Verification

USCIS

Department of Homeland Security

U.S. Citizenship and Immigration Services

Form I-9

OMB No. 1615-0047

Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
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
INEGBEDION	SAMUEL	COSTAL HEALTHCARE SYSTEMS INC

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
23527 BAKER HILL DRIVE	RICHMOND	TX	77469

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 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 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. 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		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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 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		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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

COASTAL HEALTH CARE SYSTEMS INC.

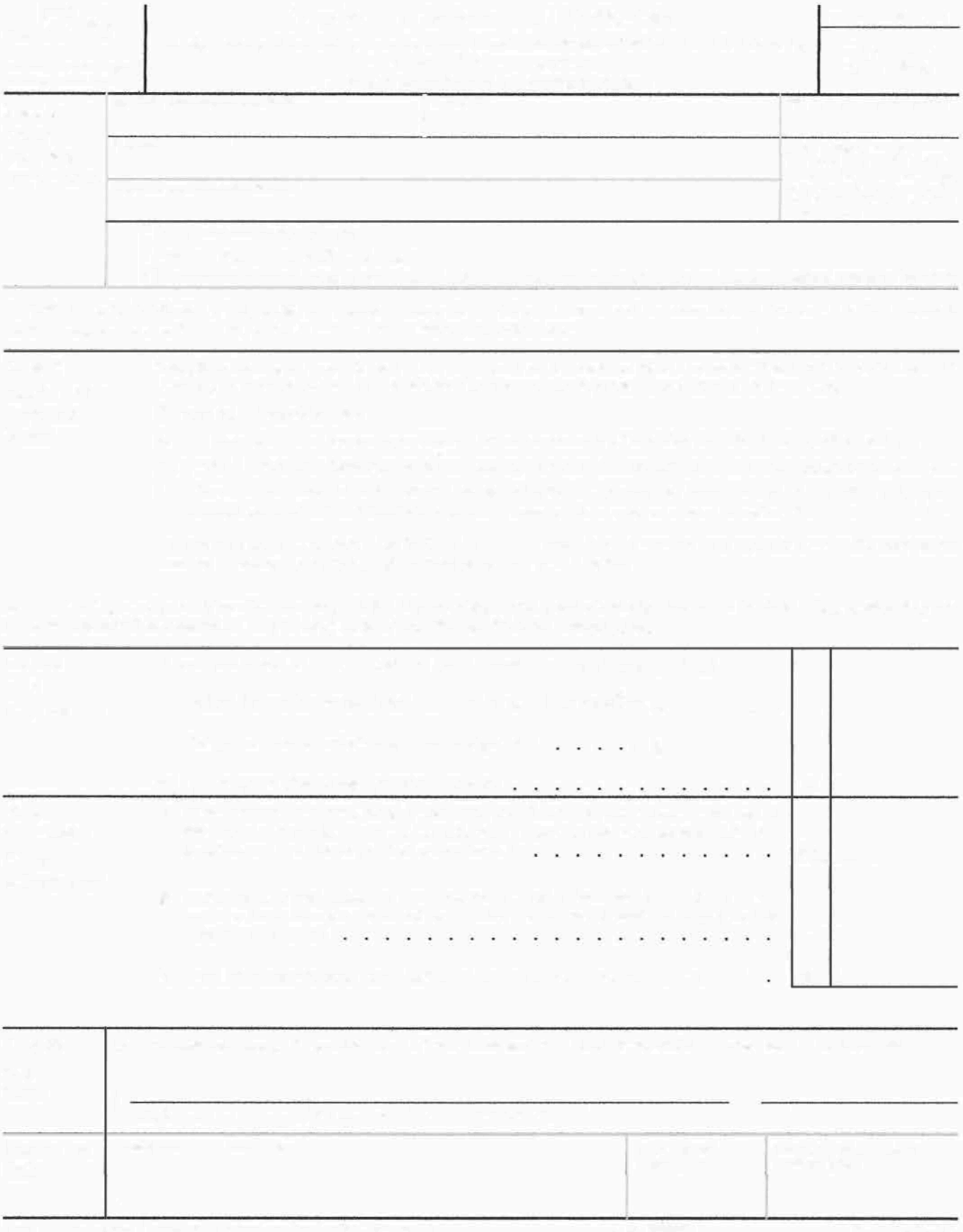
Form **W•4**

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**

0MB No. **1545-0074**

@20



COASTAL HEALTH CARE SYSTEMS INC.

Department of the Treasury
Internal Revenue
Service

► Give Form W-4 to your employer.

► Your withholding is subject to review by the IRS.

Step 1;

Enter

Personal

Information

(a) First name and middle initial | Last name

Address

City or town, state, and ZIP code

(b) Social security number

► Does your name match the n me on your social security card? If not, to ensure you get credit for 800 your 772 earnings, 1213 contact SSA at or go to ***www.ssa.gov.***

(c) D **Single or Married fifing separately**

D **Married fifing Jointly** (or Qualifying widow(er))

D **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2:

Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do only one of the following.

(a) **Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3-4); or**

(b) **Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or**

(c) **If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option**

; **otherwise, more tax than necessary may be withheld • . . . . ►** Disaccurateforjobswithsimilarpay

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

Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other Jobs. (Your withholding will be most accurate If you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

Step 3:

Claim

Dependents

If your Income will be $200,000 or less ($400,000 or less *if* married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ►

−$ '-------

Multiply the number of other depend

Add the amounts above and enter the total here

(b) **Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here**

(c) **Extra withholding. Enter any additional tax you want withheld each pay period**

Step4 (optional): Other

Adjustments

(a) **Other income (not from jobs). If you want tax withheld for other Income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement Income**

COASTAL HEALTH CARE SYSTEMS INC.

3 $

1-4(,b)"-+'-$_____

4(a) $
|'--'-'- ¦ -----

4(c) $

Step 5: Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, Is true, correct, and complete.

Sign Here ▶ **Employee's signature (This form Is not valid unless you sign It.)** ▶ **Date**

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)
	COASTAL HEALTHCARE SYSTEMS INC 23527 BAKER HILL DR, RICHMOND TX 77407		862-2540253

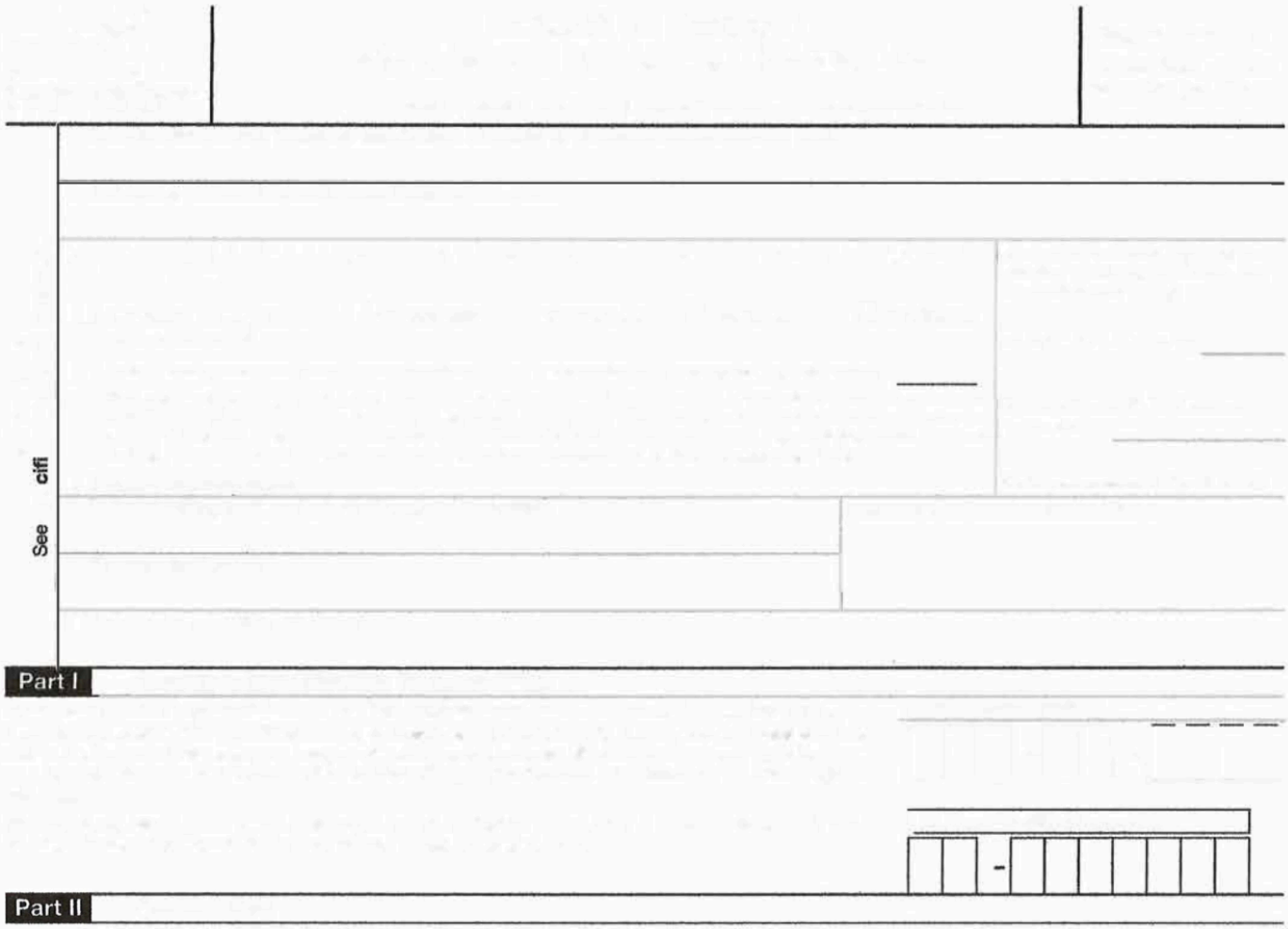
For Privacy Act and Paperwork Reduction Act Notice, see page 3. **Cat.** No. **102200** Form W-4 **(2020)**

COASTAL HEALTH CARE SYSTEMS INC.

Form **W-9**

Request for Taxpayer

Give Fonn to the



COASTAL HEALTH CARE SYSTEMS INC.

(Rev. October 2018)

Identification Number and Certification

requester. Do not send to the IRS.

Department of the Treasury

► Go to *www.irs.gov/FonnW9* for instructions and the latest information.

Internal Revenue Service

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.

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

Exempt payee code (If any)

g\

0. C 0 Individual/sole proprietor or

0 c Corporation

0 s Corporation

0 Partnership

0 Trust/estate

!! □ single-member LLC limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P:Partnership) ►

□ Notl'r. Check the approp1\ate box in the line above fOl' the tax classification of the sing\e-membef ownllf. Do not check

s LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owne1 of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. OtheTwise, a single- member LLC that

a. u is disregarded from the owner should check the appropriate box for the tax classification of its owner.

Exemption from FATCA reportlng code (if any)

/Applies to acc011nts ma/nts/119d outside the U.S.)

| 0 Other (see instructions) ►

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) he1e (optional)

Taxpayer Identification Number (TIN)

Enter your TIN, later.

TIN In the appro rlate box. !he TIN provided must, match the name given on line 1 to avoid backup withholding. For Individuals, this Is .generally your .social security number (SSN). How.ever, for a resident alien, sole proprietor, or disregarded entity, see the Instructions for Part I, later. For other entitles, it Is your employer Identification number (EIN). If you do not have a number, see *How to* get *a*

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.

I Social security number

DJJ_ -JD -I I I I I

! Employer Identification number

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.

CertfficatIon Instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholdinlJ 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 tor Part II, later.

Sign Here I Signature of U.S. person► Date►

General Instructions

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

- Form 1099-DIV (dividends, Including those from stocks or mutual funds)
- Form 1099-MISC (various types of Income, prizes, awards, or gross proceeds)

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 0nterest earned or paid)

• 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 0ncluding 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.

COASTAL HEALTH CARE SYSTEMS INC.

Employee Information Worksheet

*Required Field

*Name (First, Last) _____

*Address _____

_____

*Social Security # _____

*Marital Status _____

*Dependents _____

*Date of Birth _____

Rate of Pay _____

Hire Date _____

* *Direct Deposit information*

Name of Bank _____

□ Checking

Account # _____

Routing # _____

□ Entire Net Pay

□ Dollar Amount _____

□ Savings

Account # _____

Routing # _____

□ Entire Net Pay

□ Dollar Amount _____

Include a voided check.

COASTAL HEALTH CARE SYSTEMS INC.

1099 Contractor Information

Name (Last, First) _____

Address _____

_____

Social Security Number or TIN _____

Rate of Pay _____

Direct Deposit information (if applicable):

Bank Name: _____

ACCOUNT#:_____

Routing #: _____

Type of Account: □ Checking □ Savings **Include a voided**

check.

COASTAL HEALTH CARE SYSTEMS INC.

EMPLOYEE OFFER LETTER

Date: _____

Employee name:

Address:

Dear

We are pleased to confirm our job offer to you as a full-time employee working in the capacity of a Nurse (RN) reporting directly to DON/Administrator. You will be compensated at the rate $_____/hr worked and payable bi-weekly and at the rate $_____/hr worked for Trach/Vent patients. You have advised us that you will commence employment immediately if a client is assigned to you and your orientation will be scheduled a day prior to commencement.

This offer is contingent upon your ability to successfully complete the remainder of the Company's employment process that may include the following: the ability to verify eligibility to work in the United States (I-9); successful completion of a routine background investigation; license/certification verification; satisfactory completion of a health questionnaire. Your employment, like everyone's employment in our Company, is considered "employment at will." Either you or Coastal Health Care Systems Inc. may end your employment at any time, for any reason, with or without cause.

I am certain I am speaking for the entire Coastal Health Care Systems Inc. Inc in stating that we are delighted to extend this offer of employment. I believe your experience with Coastal Health Care Systems Inc. will prove exciting and meaningful. I am certain you will be a welcome addition to the Coastal HealthCare Systems team and a valuable contributor to the achievement of our business goals.

Please indicate your acceptance of, and agreement to, the foregoing by signing the enclosed copy of this offer letter were indicated and returning it all to me.

Sincerely,

_____

Samuel Inegbedion

Administrator

I accept the employment, and its terms, contained in this letter. I have received no other promises other than those contained in this letter.

Employee Signature: _____

Employee name_____ Date _____