Pamir Healthcare Services LLC

The New Era Of Healthcare

APPLICATION FOR HIRING AS INDEPENDENT CONTRACTOR – AIDES

Personal Information

Date: _____

PLEASE PRINT OR USE ALL CAPITAL LETTERS IN WRITING YOUR NAME AND ADDRESS

Last Name: _____ First Name: _____ MI: ____

Date of Birth: _____ Email address: _____

Social Security Number: _____ EIN: _____ { } Male { } Female

Street Address: _____ City: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Phone number: _____

EMPLOYMENT INFORMATION Date available for work: _____

Certification: (Check all applicable): [ ]Nurse [ ]CAN/HHA [ ]PCA [ ]MedTech [ ]OTHER: _____

Shift Desired: (Check all applicable): [ ]Part Time [ ]Full Time [ ]Day Shift [ ]Night Shift

Days of Availability: [ ]All [ ]Mon [ ]Tues [ ]Wed [ ]Thurs [ ]Fri [ ]Sat [ ]Sun Hours: _____

Do you possess a valid Driver's License? [ ]YES [ ]NO

Do you have your own transportation? [ ]YES [ ]NO

Have you applied at **Pamir Healthcare** before? [ ]YES [ ]NO If so, When: _____

How were you referred to us? _____

Name of Person Who Referred: _____ Contact Number: _____

Can you perform all the job-related functions of the position(s) you are applying for? [ ]YES [ ]NO

If no, please explain: _____

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Education

School Name Location Dates(s) Attended Graduated Yes/No Area of Study

_____

_____

_____

_____

Certification(s): _____ State: _____

Do you have documentation of this certification: [ ]YES [ ]NO

If not, please explain: _____

_____

Work Experience – provide information about your employment for the past 5 years. Start with the most recent experience

Dates	*Company*	*Address*	*Job Title/Description*	*Salary*	*Reason for Leaving*

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Do you have a Background Check: [ ]YES [ ]NO

Have you ever been charged or convicted of abuse, neglect, assault, exploitation, deprivation or injury of any person - [ ]YES [ ]NO If "YES", please explain:

_____

_____

Have you been screened for TB? [ ]YES [ ]NO When: _____

Have you been exposed to TB or Hepatitis? [ ]YES [ ]NO Please explain:_____

_____

I understand that the clients I will be working with are the clients of Pamir Healthcare. I also understand that in the event the contract between Pamir Healthcare and the client(s) is terminated due to any reason, I cannot work with that client or their family for at least one year either independently or with another agency. Should this happen, Pamir Healthcare will take full legal action. I also understand that this is a contractor position where I will be issued a form 1099 and that I will be responsible to submit my taxes to the IRS (please consult a CPA for further details.) I certify that the answers given herein are true and complete to the best of my knowledge.

_____ _____

Signature of Applicant *Date*

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Caregiver Skill Assessment Form

Name: _____

Directions: for each task listed, please answer the two questions listed. Competence means "The ability to perform the procedures safely, correctly, effectively and professionally." Scale: 1-4, Where 1 means the least competency; and 4 means the highest competency.

Task		Have you ever done this before?		Are you competent performing? Please circle the number				Comments
ACTIVITIES OF DAILY LIVING	Bathing	Yes	No	1	2	3	4	
	Personal Hygiene (i.e. Hair, oral, nail and skin care)	Yes	No	1	2	3	4	
	Toileting (i.e. bladder, bowel, bed pan, routines, e.t.c.)	Yes	No	1	2	3	4	
	Dressing & Changing Clothes	Yes	No	1	2	3	4	
	Mobility & Transfers	Yes	No	1	2	3	4	
	Eating & Drinking	Yes	No	1	2	3	4	
INSTRUMENTAL ACTIVITIES	Meal Preparation	Yes	No	1	2	3	4	
	Light Housekeeping	Yes	No	1	2	3	4	
	Grocery Shopping	Yes	No	1	2	3	4	
	Transportation/Traveling in the Community	Yes	No	1	2	3	4	
	Laundry	Yes	No	1	2	3	4	
	Handling Money	Yes	No	1	2	3	4	
	Using the Telephone	Yes	No	1	2	3	4	
	Reading of Specific Items	Yes	No	1	2	3	4	
	Wash Equipment	Yes	No	1	2	3	4	
	Other	Yes	No	1	2	3	4	

Signature: _____ Date: _____

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Reference Check

Please provide three job/professional references including their daytime phone number

Applicant Name: _____

Applicant Home Phone #: _____ Applicant Cell Phone #: _____

1. First Reference Name: _____ Title: _____
   Company Name: _____ Telephone #: _____

   For Office Use Only – Do Not Write In This Space
   Date Contacted: _____ Staff Responsible: _____
   Comments: _____

2. Second Reference Name: _____ Title: _____
   Company Name: _____ Telephone #: _____

   For Office Use Only – Do Not Write In This Space
   Date Contacted: _____ Staff Responsible: _____
   Comments: _____

3. Third Reference Name: _____ Title: _____
   Company Name: _____ Telephone #: _____

   For Office Use Only – Do Not Write In This Space
   Date Contacted: _____ Staff Responsible: _____
   Comments: _____

Applicant Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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Verification of Previous Employment

To Be Completed By The Applicant

I hereby authorize Pamir Healthcare to contact all past employers and other individuals, agencies or entities concerning the information I have supplied and waive, release and hold harmless such individuals, agencies or entities from any claims arising from the information they may provide to Pamir Healthcare.

Applicant's Name: _____
Name of Prior Employer/Company: _____
Address: _____
Phone #: _____ Fax #: _____
Employed From: _____ To: _____
Position with Company: _____
Signature: _____ Date: _____

STOP – FOR OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE

The above applicant has applied for employment/contract with us. Your evaluation will be greatly appreciated.

PHS Signature: _____ Date: _____

TO BE COMPLETED BY FORMER/CURRENT EMPLOYER

Position Held: _____

Employment Dates: From: _____ To: _____

Days Worked: _____ Hours Worked: _____

Reason for Leaving: _____
_____
_____

Your Name: _____ Employer: _____ Title: _____

Signature: _____ Date: _____

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SWORN DISCLOSURE STATEMENT

Section 32.1 – 1629:1 of the Code of Virginia Requires that any person desiring work at a licensed homecare provider agency provide the hiring facility or center with a sworn disclosure statement or affirmation disclosing any criminal convictions or pending criminal charges, whether within or outside the commonwealth of Virginia.

The law prohibits licensed assisted home care agency from hiring any individuals convicted of the following Murder or manslaughter, malicious wounding mob, abduction, abduction for immoral purposes, assaults and bodily wounding's, robbery, carjacking, threats of death or bodily injury, felony stalking, sexual assault, arson, drive by shooting, use of a machine gun in a crime of violence, aggressive use of a machine gun, use of a sawed-off shotgun in a crime of violence, pandering, crimes against nature involving children, incest, takin indecent liberties with children, abuse and neglect of children, failure to secure medical attention for an injured child, obscenity offenses, possession of child pornography, electronic facilitation of pornography, abuse and neglect of incapacitated adults, employing or permitting a minor to assist in an act constituting an obscenity or related offense, delivery of drugs to prisoners, escape from jail, felonies by prisoners; or equivalent offense in another state. However applicants convicted of one misdemeanor barrier crime not involving abuse or neglect may be hired if five years has elapsed since the conviction.

Any person making a false statement on this form regarding any criminal offense shall be guilty of a Class 1 misdemeanor.

Further dissemination of the information provided on this form is prohibited other than to the commissioner's representative or federal or state authority or court as many be required to comply with an express requirement of law for such further dissemination.

1. _____

Last Name First Middle Maiden Social Security Number

_____

Street/P.O. Box City State Zip Code

2. Have you ever been convicted of a law violation(s) but excluding offenses committed before your eighteenth birthday that were finally adjudicated in a Juvenile court or under a youth offender law?
[ ]YES [ ]NO If YES, list all then explain. _____

_____

_____

_____

_____

_____

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3. Are you the subject of any pending criminal charges? [ ]YES [ ]NO

   If yes, list all and explain. _____

   _____

   _____

   _____

   _____

   _____

4. I hereby affirm that the information provided on this form is true and complete, and I agree and understand that any falsification of information herein, regardless of time of discovery, may cause forfeiture on my part to any employment offered by this facility. I understand that all information on this form is subject to verification.

Applicant's Signature: _____ Date: _____

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Orientation Documentation

Name: _____

Date: _____

	Initials
1. Objectives and philosophy of the Organization	_____
2. Confidentiality	_____
3. Client Rights	_____
4. Mandated reporting of abuse, neglect and exploitation	_____
5. Applicable personnel policies	_____
6. Emergency preparedness procedures	_____
7. Infection control practices and measures	_____
8. Cultural awareness	_____
9. Applicable laws, regulations and other policies and procedures that Apply to specific positions, specific duties and responsibilities	_____

Contractor Signature: _____

PHS Staff signature: _____

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CAREGIVER JOB DESCRIPTION

- Provide personal care service to the client for which the client needs physical assistance. Some examples of personal care are listed below:
  - Ambulation – physically assisting a patient who otherwise would be unable to move about independently
  - Personal hygiene –which includes bathing the patient
  - Dressing – physically applying a patients clothing to the patient's body
  - Toileting – assisting a patient to go to and from toileting facilities and in the activities of toileting.
  - Eating – includes hand feeding a patient who is incapable of self – feeding
- Provide competent, sate of the art care to its patients.
- Follow the Caregiver Service Plan (CSP) to perform the tasks agreed upon.
- For security reasons, the caregiver should not disclose or knowingly permit the disclosure of any information in a client record except to appropriate provider staff, the Client, responsible party (if applicable), the client's physician or other healthcare provider, the regulatory department, other individuals authorized by the client in writing or by subpoena.
- In case of an emergency at the client's home, the caregiver must immediately contact the Client's emergency contact name (as stated in the client's file), and notify the Pamir Healthcare office.
- The caregiver must notify Pamir Healthcare office and the Client's responsible party of any changes in the Client's condition.
- The caregiver is encouraged to report to the office any changes that may improve the quality of care a patient is receiving.
- Reports to Administrator.

Contractor Signature: _____ Date: _____

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Confidentiality/HIPAA Agreement

This Confidentiality/HIPAA Agreement between Pamir Healthcare (hereinafter "Company") and, _____ (hereinafter "Contractors") is effective as of _____.

Confidentiality/Application of HIPAA

Contractors agree to maintain the confidentiality of all Company and Client information and affairs. All records containing Company's client names, addresses and other information must be surrendered upon termination of contracts. Except as required in the performance of services hereunder, Contractors will not, during the term of contracts or after termination, use or disclose any confidential or proprietary information of Company or Client, or Client's Patients, without first obtaining the consent of Company and where appropriate, Client and patient. In addition, Contractors Agrees to maintain the confidentiality of information about Contractor's wages and other compensation. Contractors agree to maintain the confidentiality of all Company and Client information and affairs. To the extent that Contractors and Company may qualify as a "business Associate" as defined by the health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and privacy regulations published by the U.S. Department of Health and Human Services contained at 45 CFR §§ 160 and 164 ("HIPAA Regulations"), which may be periodically revised or amended, and other applicable laws, Contractors and Company agree to protect and provide for the privacy and security of Protected Health Information ("PHI"), as defined by HIPAA.

The parties agree as follows:

A. Contractors and/or agents shall use appropriate safeguards to prevent the use and/or disclosure for all PHI relating to patients, patients' family members, Clients' employees, Company's employees and other Healthcare providers-made available by or obtained from Patient, Client or Company.
B. Contractor's disclosure of PHI shall be limited to only those purposes that are necessary to perform its employment obligations and specifically detailed in Contractors' job responsibilities, unless otherwise agreed by the Parties.
C. Contractors shall not: (a) use or further disclose any PHI except as provided with the prior written approval of Company and Client; or (b) use of further disclose any PHI Except as provided with the prior written approval of HIPAA or its regulations. Contractors shall immediately report to Company and Client in a timely manner any unauthorized use or disclosure of PHI of which the contractors become aware.
D. Upon termination of contract, Contractors shall return all PHI that Contractors maintains in all form and retains no copies of such PHI without the prior written approval of Company and Client. If Employee is unwilling or unable to return such PHI, Contractors shall destroy all PHI, regardless of whether its form is paper or electronic.
E. Contractors will indemnify, hold harmless and defend Company and Client from and against any and all claims, losses, liabilities, costs and other expense incurred as a result or arising directly or indirectly out of or in connection with any unauthorized use of disclosure of PHI by Contractors.

This Provision is not intended to restrict or otherwise limit the application of HIPAA to the parties. This provision is intended only to outline the parties' general duties as required by HIPPA. Contractors and Company recognizes that they are fully subject to all provisions of HIPPA, regardless of whether these provisions are outlined in the above provision. This HIPAA provision shall survive the termination of this Agreement.

Contractors:

By: _____ Date: _____

Pamir Healthcare Services

By: _____ Date: _____

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PRE-EMPLOYMENT BACKGROUND CHECK AUTHORIZATION

I, _____, understand that as part of the employment process, **Pamir Healthcare** needs to complete a background check on me regarding:

1. Criminal record;
2. Sex and violent offenders Record;
3. Employment Verification
4. Education Verification;
5. License Verification
6. Motor Vehicle Records;
7. Personal Professional Reference Verification;
8. Medical Suitability
9. Drugs/Alcohol

I authorize all federal and state agencies, persons and organizations that may have information relevant to this research to disclose such information to **Pamir Healthcare** or its authorized agent(s).

I understand that this authorization is to be part of the written and signed employment application.

I also understand that I do not have to give authorization for a background check but if I don't give permission my employment application will not be processed further.

I understand that I have specific rights under the federal Fair Credit Reporting Act (FCRA) and may have additional rights under relevant state law.

I further authorized that a photocopy of this authorization may be considered as valid as the original

I hereby certify that all statements on this form are true and correct to the best of my knowledge and belief. I understand that employment **Pamir Healthcare** is contingent upon successful completion of a background check.

_____ _____

Signature Date

Full Name: _____ Telephone No.: _____

Former/Maiden Name: _____

Current Address: _____

Date of Birth: _____ Social Security Number: _____

Current Driver's License Number: _____ State: _____

_____ Deduct $15 from my payroll check to cover the criminal background check.

Initial

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EMPLOYER & CONTRACTOR AGREEMENT

Employer: _____
Business Name: _____
Address: _____
Phone: _____ Fax: _____ Email: _____

Contractor:
Last Name: _____ First Name: _____
Address: _____
Phone: _____ Fax: _____ Email: _____

The parties agree as follows:

1. **Duration of Contract**
   This contract shall have duration of 12 months from the date THE CONTRACTOR assumes his/her Duties. The "Term of Contractor")
   Both parties agree that this contract is conditional upon THE CONTRACTOR obtaining a valid work permit pursuant to the Immigration Regulations.

2. **Job Description**
   THE CONTRACTOR agrees to carry out the task as outlined in their job title/description.
   $____ per week, or $_____ per hour. These shall be paid at intervals of _____.
   THE EMPLOYER is NOT responsible for Income Tax Withholding, Social Security and Medicare taxes and Federal Unemployment Tax Act (FUTA).
   THE EMPLYER is NOT responsible for depositing income tax withheld and both the employer and employee social security and Medicare taxes.

3. **Notice of Resignation**
   Should he/she wish to terminate the present contract, THE CONTRACTOR agrees to give THE EMPLOYER written notice thereof at least two weeks in advance.

4. **Notice of Termination of Employment**
   THE EMPLOYER may terminate CONTRACTOR with no advance notice and no severance pay if CONTRACTOR has violated the terms of this or any other agreement, or has been negligent or act in a way that could have allowed harm to Client.

5. **Non-Solicitation of Clients**
   THE CONTRACTOR agrees not to solicit or accept independently and clients of THE EMPLOYER during their employment with THE EMPLOYER and for a period of 1 year after termination of employment with THE EMPLOYER.

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IN WITNESS WHERE OF the parties state that they have read, understand and accept all the terms and conditions stipulated in the present agreement/contract.

_____ _____

Signature of Employee Date

_____ _____

Signature of Employer Date

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