20 PTS

Pass: 60

Margin: 3 to Pass

EDISON HOME HEALTH CARE

Name:_____ Date:_____

PRE-APPLICATION TEST

1. Before helping a client out of a wheelchair to their bed, you should make sure the wheelchair wheels are locked.

☐ True ☐ False

2. The First thing I should do if the patient falls is call 911

☐ True ☐ False

3. Something that will help to prevent accidents in the patient's is to keep the hallways free of clutter

☐ True ☐ False

4. The Aide should communicate with the client who has a hearing loss by facing the client when speaking

☐ True ☐ False

5. Proper hand washing requires lathering with soap for at least:

☐ 20 seconds ☐ 3 minutes ☐ 5 minutes

EDISON
HOME HEALTH CARE

HOME CARE EMPLOYMENT

REFERENCE REQUEST

To: _____ **Title:** _____ **Agency:** _____

Name of Applicant: _____

Position Applied for: _____

Release of Information

I _____, hereby authorize the release of all information requested by Edison Home Health Care. I release you from all responsibility/liability regarding the information provided by you from our past association.

Applicant's Signature: _____ **Date:** _____

The person identified above has applied for a position at Edison Home Health Care. Would you kindly complete the references information below and return the reference information? This information will be kept confidential. Thank you.

Position held at your organization: **HHA** _____ **PCA** _____ **Other** _____

Reference's relationship to applicant: _____

Dates of Employment: **From:** _____ **To:** _____

Employee Performance: ☐ **Satisfactory** ☐ **Unsatisfactory**

Reason for Leaving: _____

Would you re-employ? _____**Yes** _____**No** **If No, why?** _____

***

Additional Comments: _____

_____

Signature: _____ **Date:** _____

COMPANY'S STAMP

Revised 2/17/20 DK

EDISON
HOME HEALTH CARE

Employment Application

Last Name: _____ First: _____ Middle initial: _____

Address: _____Apt #_____ City_____ State_____ Zip code _____

Home Phone Number: _____ Cell Phone Number: _____

Training: Do you have a HHA Certificate? Yes☐ No☐

Do you have a PCA Certificate? Yes☐ No☐

Name Training Program _____ Date of Completion: _____

Home Care Employment History

Company Name: _____ Supervisor: _____

Address: _____

Phone Number: _____ Dates of Employment: _____

Job Title: _____ Reason for Leaving: _____

Emergency Contact

Name: _____ Relation: _____

Phone Number: _____

*****

Name: _____ Relation: _____

Phone Number: _____

Availability: ***Do you use a car to get to and from work? Yes____ No ____***

Days:

☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Saturday ☐Sunday

Hours:

☐ 4 hours
☐ 8 hours
☐ 12 hours
☐ **Live-in**

Are pets OK? _____

Is smoking OK? _____

Location of Preference: _____

Languages: _____, _____, _____, _____

Messages: May we send you text messages if necessary? No☐ Yes☐ please provide telephone _____

You understand and agree that text messages will be provided for informational purposes only. Some fees and text messaging rates may apply based on the plan you have with your cellphone carrier.

E-Mail Address: _____

Edison Home Health Care ensures equal opportunity to all employees and applicants regardless of their race, color, gender, sex, religion, age, creed, marital status, familial status, national origin, ancestry, past or present physical or mental disability, sexual orientation, gender identity, affectional preference, veteran status, citizenship status, genetic information, uniform service member status, and any other classification protected by law

I affirm that the information in this application is complete and true. I understand that if employed, false statements will be a cause for dismissal.

Signature: _____ Date: _____

Revised 2/17/20 DK

EDISON
HOME HEALTH CARE

Release Form

I, _____, have applied for a position as a _____HHA / PCA_____ with Edison Home Health Care. All of the information I have submitted is true to the best of my knowledge. All certificates are valid (or copies of originals) and all background information is correct. I authorize Edison Home Health Care to obtain any information regarding and pertaining to my employment and health status. I understand that this may include contacting the following to obtain information to verify signatures, dates, forms and data.

- Medical providers (M.D. lab, etc…)
- Previous employers
- Schools and training programs
- Personal and professional references

I further release Edison Home Health Care of any liability that may occur as a result of my personal negligence or as a result of any information that I wrongfully or fraudulently submitted to Edison Home Health Care or in the course of applying for a position during my association with them. I understand that any information fraudulently submitted will result in my immediate termination.

As a job applicant/employee of Edison Home Health Care I hereby attest to the fact that I have received no special inducements, remuneration, or promises thereof to work for this agency. I understand that I will receive a salary commensurate and also in line with what other employee of this agency are receiving for similar work and experience. All other benefits that I may be eligible for will be in accordance with policies established by Edison Home Health Care.

Hiring of personnel, salaries and benefits are awarded without regard to race, religion, disability, marital status, or sexual orientation. Edison Home Health Care is an equal opportunity employer. I have read the preceding statement and I understand and agree with its contents.

Employee Signature: _____ **Date:** _____

NYS Department of Health, Criminal History Record Check Unit

chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

Last Name	First Name	Middle Initial	Maiden Name

Date of Birth (mm/dd/yyyy)	Alias/AKA	Mother's Maiden Name

Mailing Address (street)	City	State	ZIP Code

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary. In accordance with applicable laws, DOH will furnish appropriate summary information to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for any non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.

NYS Division of Criminal Justice Services
Criminal History Bureau
Record Review Unit-5th Floor
4 Tower Place
Albany, NY 12203
(518) 485-7675

Federal Bureau of Investigation
Criminal Justice Information Services
(CJIS) Division
1000 Custer Hollow Road
Clarksburg, WV 26306

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7. I certify to the best of my knowledge and belief that I (check as appropriate):
   - ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
   - ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you checked either "Have" and/or "Do", please provide a brief explanation. (Optional)

   _____
8. My current mailing or home address is indicated in Section 1 of this form.
9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own.

Applicant Signature: _____ Date: ____/____/_____

Name and Signature of Parent or Legal Guardian: _____ Date: ____/____/_____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: Edison Home Health Care	Operating License Number (PFI): 1815 L00
Print Name of Authorized Person: Aferdita Kodraj	Title: Director of HR
Signature of Authorized Person: Aferdita Kodraj	Date:

EDISON
HOME HEALTH CARE

FINGERPRINT INFORMATION

LIC# 1815 L00 .

Date:_____

First Name:_____

Middle Name:_____

Last Name:_____

Address: _____APT#:_____

City:_____ State:_____ Zip:_____

Phone #: (_____)_____

Last 4 of your SS #:_____

Date of Birth:_____

Birth Country/Place:_____

Gender:_____

Race:_____

Height: _____feet_____inches

Weight:_____

Eye Color:_____

Hair Color:_____

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
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
	1 1 1 - 1 1 -		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		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				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

EDISON
HOME HEALTH CARE

HEPATITIS B VACCINE ACCEPTANCE / DECLINATION FORM

ACCEPTANCE:
I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of being infected by bloodborne pathogens, including Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV).
This is to certify that I have been informed about the symptoms and the hazards associated with these viruses, as well as the modes of transmission of bloodborne pathogens. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. In addition, I have received information regarding the Hepatitis B (HBV) vaccine. Based on the training I have received, I am making an informed decision to accept the Hepatitis B (HBV) vaccine.

DECLINATION:
I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this 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 vaccination series at no charge to me.

CHECK ONE: ☐ I DECLINE Hepatitis B vaccine inoculation:

OR

☐ I ACCEPT Hepatitis B vaccine inoculation.

_____	_____	_____
Employee's Name (print)	Employee's Signature	Date

EDISON
HOME HEALTH CARE

946 McDonald Avenue • Brooklyn, NY 11218 • T. 718 972 2929 • F. 718 972 2323 • info@edisonhhc.com • www.edisonhhc.com

January 1, 2020

Dear Employee:

As of January 2020, the Department of Health requires that all employees with direct patient contact, receive the flu vaccine during the flu season, or be required to wear a mask **at all times** whenever in the patient's presence.

You **MUST** choose one of the three choices below to address this:

1. **Go to your own doctor for the flu shot.** If you decide to go to your own doctor for the flu shot, please have them fill out the attached document called **Annual Influenza (Flu) Vaccination Verification 2020-2021 Flu Seasons**. **You must return this completed form to Edison or Fax it to 718-972-2323**.

2. **You can decline to take the flu shot.** If you decide to decline the flu shot, you must fill out the **Flu Vaccine Declination** form**. This form must be returned to Edison.** Please return this form to Edison as soon as possible or fax it to 718-972-2323. **You must remember to wear a FACE MASK at all times while in the patient's presence until the flu season ends.**

Failure to comply with one of the 2 choices above will result in your eventual inability to be staffed on cases. Please make sure to respond to this situation quickly.

We thank you for your cooperation in this matter!

EDISON
HOME HEALTH CARE

FLU VACCINE DECLINATION

- I have been advised that the influenza vaccine is recommended by the CDC and I should receive the vaccine to protect myself, the patients I serve, my coworkers, my family, and the community.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year.
- Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
- Up to 30% of people with influenza have no symptoms, allowing transmission to others.
- Flu virus changes often, making an annual vaccination a necessity.
- I understand that flu vaccine **cannot** transmit influenza.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others and they can become seriously ill.

Despite these facts, **I will NOT be getting the flu vaccine for the 2020-2021 Flu season** for the following reason(s). Please check all that apply.

☐ I have an allergy or medical contraindication to receiving the vaccine
  ☐ Severe allergies to eggs, vaccine components, or prior influenza vaccines.
  ☐ History of Guillain-Barre Syndrome.
☐ I believe I will get the flu if I get the shot.
☐ My philosophical or religious beliefs prohibit vaccination.
☐ I do not like needles.
☐ I never get the flu.
☐ I don't believe this vaccine is important.

Other reason – please tell us _____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

During the flu season, I agree to wear a SURGICAL MASK at all times while in the patient's presence until the flu season ends.

I understand that failure to comply with these requirements will put me and the patient(s) I care for at risk, and my employment with Edison HHC is conditional on meeting these requirements.

_____	_____	_____
Employee Name (print)	Employee Signature	Date

EDISON
HOME HEALTH CARE

HOW DID YOU HEAR ABOUT EDISON?

Newspaper/Magazine:
- (•) Employment Guide
- ( ) El Diario
- ( ) Correro
- ( ) Sing Tao
- ( ) Ridgewood Times
- ( ) World Journal
- ( ) Other: Name: _____

Training School:
- ( ) Efficient / Bridge Careers
- ( ) Beacon
- ( ) Bulkan's
- ( ) Other: Name: _____

Website:
- ( ) Edison HHC
- ( ) Indeed
- ( ) Craiglist
- ( ) Other: Name: _____

Edison Rep.:
- ○ Name:_____
- ○ Name:_____

Friends:
- ○ Name:_____

Ask about our "Refer a Friend Program"