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

EMPLOYEE #:_____

New Employee Checklist

Employee Name **Hire Date**

Title **Department** **Supervisor Name**

EMPLOYEE NEEDS:

- ☐ Offer letter and Salary Form
- ☐ Job Description
- ☐ Copies of Picture ID and Social
- ☐ Employment application package
- ☐ I-9 Form
- ☐ E-Verify
- ☐ C3 Intelligence **(Nurses and HPS)**
- ☐ Employee ID (From ADS Payroll)
- ☐ Access to Clock in and out (Fingerprint)
- ☐ Enter information in Easy Clock In
- ☐ Announcement email (Welcome)
- ☐ New Employee Set Up to Administrator
- ☐ Department Buddy _____
- ☐ Space
- ☐ Desk / Chair
- ☐ Supplies
- ☐ Computer
- ☐ Telephone / Extension
- ☐ Cellphone
- ☐ Laptop
- ☐ Business Cards
- ☐ Set up Direct Deposit

EMPLOYEE NEEDS ACCESS TO:

- ☐ Computer log in
- ☐ Email address
- ☐ Email groups
- ☐ HHA Exchange
- ☐ PaperVision
- ☐ C3 Intelligence

HR STAFF:

- ☐ HCS (HCR)
- ☐ HCS (CHRC)
- ☐ E-Verify

FINANCE STAFF:

- ☐ Millennium
- ☐ ADS

RN STAFF

- ☐ Pre-employment test
- ☐ Application
- ☐ Licenses and Certifications
- ☐ License Verification
- ☐ IDs
- ☐ References
- ☐ Malpractice Insurance
- ☐ Enter in Exchange
- ☐ Time reporting (Per Diem nurses, marketers, and HHA Supervisors)

Medical for Nurses

- ☐ Pre-employment Physical
- ☐ Drug Screen
- ☐ Rubella
- ☐ Rubeola
- ☐ PPD 1 o PPD 2
  - ☐ + PPD
  - ☐ Chest X-ray
  - ☐ TBQ
- ☐ Flu Vaccine

NOTES:_____

_____

_____

_____

_____

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For Office Use Only:
DATE OF HIRE: _____

Employment Application

Last Name: _____ First: _____ Middle initial: _____

Address: _____Apt #_____ City_____ State_____ Zip code _____

Home Phone Number: _____ Cell Phone Number: _____

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.

How did you hear about Edison HHC? Website_____; Newspaper/magazine:_____;
Training School: _____; Friend_____

Emergency Contact: _____ Phone Number: _____ Relation:_____

Languages: _____

Education: Do you have a High School Diploma: Yes☐ No☐
Some College Yes☐ No☐
College Degree Yes☐ No☐

Work History

Company Name: _____ Supervisor: _____
Address: _____
Phone Number: _____ Dates of Employment: _____
Job Title: _____ Reason for Leaving: _____

Company Name: _____ Supervisor: _____
Address: _____
Phone Number: _____ Dates of Employment: _____
Job Title: _____ Reason for Leaving: _____

References

Character References: *(Could include teacher, landlord, doctor, priest/rabbi)*

Name: _____
Address: _____
Phone Number: _____

*****

Name: _____
Address: _____
Phone Number: _____

Edison Home Health Care does not discriminate because of age, sex, physical handicap, race, creed, sexual orientation and any other protected classification, or national origin. This agency is an equal opportunity employer.

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:** _____

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CORPORATE COMPLIANCE / CONFLICT OF INTEREST NON-SOLICITATION AND NONCIRCUMVENTION

As an employee of Edison Home Health Care (the agency), I,_____, understand that any attempt on my part to provide services to a patient without the knowledge of the agency would be harmful and damaging to the agency. I agree that during the term of my employment with the agency and for a period of ninety (90) days after the end of my employment:

1. I will not in any way, directly or indirectly, offer to provide services to any of the agency's patients without the agency's actual knowledge, authorization and consent.

2. I will not in any way, directly or indirectly, accept a patient's offer to hire me directly without the agency's actual knowledge, authorization and consent.

3. I will not in any way, directly or indirectly, actually provide services to any of the agency's patients without the agency's actual knowledge, authorization and consent.

I recognize that a breach of this agreement can result in harm to the agency and agree that in the event of such a breach, I will be liable to pay the agency a minimum of the full payment the agency would have earned had I not circumvented the agency, plus further damages to the extent allowed by law and that the agency shall be entitled to and may seek any and all additional remedies to the extent available by law.

Employee Signature **Date**

Witness **Date**

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Acknowledgement of Receipt of the Personnel Policy and Privacy Notice

I _____ have received Edison Home Health Care Personnel Policy and Privacy Notice. My questions regarding the Personnel Policy and Privacy Notice have been answered.

I know I can contact Edison Home Health Care at the above address or telephone number if I have any other questions regarding this form.

I further understand that my employment is at will, and neither Edison Home Health Care nor I have entered into a contract regarding the duration of my employment. Except as otherwise provided in a valid and enforceable collective bargaining agreement, I am free to terminate my employment with the Edison Home Health Care at any time, with or without reason and Edison Home Health Care has the right to terminate my employment, or otherwise discipline, transfer, or demote me at any time, with or without reason at the discretion of the Facility. No employee of Edison Home Health Care can enter into an employment contract for a specified period of time, or make any agreement contrary to this policy without the written approval of the Administrator.

_____ _____

Employee's Signature **Date**

_____

Witness Signature

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CORPORATE COMPLIANCE
CERTIFICATION OF RECEIPT OF CODE OF CONDUCT AND FEDERAL FALSE CLAIMS ACT SUMMARY PURSUANT TO DRA SECTION 6032

Questions?

Edison HHC encourages employees, contractors, and agents to raise questions or concerns, and seek clarification regarding these laws or related policy issues with the compliance Officer or other designated party.

Acknowledgement:

I HAVE RECEIVED THE FEDERAL FALSE CLAIMS ACT SUMMARY OF LAWS AND EDISON HHC'S CODE OF CONDUCT AND I UNDERSTAND AND AGREE TO CONDUCT MYSELF IN ACCORDANCE WITH AND IN COMPLIANCE WITH THE FEDERAL FALSE CLAIMS ACT, THE NEW YORK FALSE CLAIMS ACT, AND NEW YORK HEALTH CARE FRAUD LAWS AND THE FACILITY'S CURRENT CODE OF CONDUCT PURSUANT TO DRA SECTION 6032.

_____
Print Name

_____ _____
Employee's Signature Date

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Acknowledgement of Receipt
Photo Identification

As an employee of Edison Home Health Care I,_____, acknowledge receipt of the agency issued photo identification badge. As required by regulation and agency policy, I agree to wear the ID when working where it is visible to the eye immediately by the patient, all the patient's family members and Supervising Nurse.

The identification badge is the property of Edison Home Health Care and will be returned to the agency upon termination of employment.

I know I can contact Edison Home Health Care at the above address or telephone number if I have any other questions regarding this form

_____ _____

Employee's Signature / Title **Date**

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HIV/CONFIDENTIALITY STATEMENT

I, the undersigned understand the importance of observing strict confidentiality policies. Therefore I agree not to discuss or release any information obtained within the agency regarding any Edison Home Health Care client, their medical record or any client's condition with any individual not directly associated with Edison Home Health Care nor with Edison Home Health Care employees who are not directly associated with that client's records will only be done with proper authorization as/or in accordance with established agency policy for release of information.

In the event you are made aware that your patient is HIV positive you cannot disclose this information to any other individual. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as permitted by law. Any unauthorized further disclosure is a violation of State Law and may result in a fine or jail sentence or both. General authorization for the release of medical or any other information is not sufficient authorization for further disclosure.

My signature on this document indicates that I understand and agree to abide by the aforementioned policies, and that any breach in the aforementioned policies will result in implementation of the disciplinary procedure up to and including possible IMMEDIATE DISMISSAL from employment at Edison Home Health Care.

My Signature below supports this statement.

_____ _____

Employee's Signature **Date**

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OFFICE STAFF HANDBOOK

TO: EMPLOYEES RECEIVING OFFICE STAFF HANDBOOK
Please read this page, sign page and give it to the Director who will file it in your personnel record.

RECEIPT OF OFFICE STAFF HANDBOOK

I have this day received a copy of the Edison Office Staff Handbook and I understand that I am responsible for becoming familiar with its contents.

This handbook/manual is for informational purposes only. I understand that any of the provisions of this applicant/employee manual/handbook may be changed, modified or deleted at any time and that the Company has the right to administer, interpret, modify, discontinue or enhance any policy, benefit, plan or program. I understand that neither this manual/handbook nor any other written or oral communications by a management representative constitutes, or in any way, creates a contract or guarantee of employment.

I have read and I understand the Company's policies regarding confidentiality. I pledge to respect the confidentiality of all information pertaining to the clients and Company. I have received a copy of the Company's confidentiality statements.

I further understand that my employment is at will, and neither Edison nor I have entered into a contract regarding the duration of my employment. Except as otherwise provided in a valid and enforceable collective bargaining agreement, I am free to terminate my employment with the Edison at any time, with or without reason and Edison has the right to terminate my employment, or otherwise discipline, transfer, or demote me at any time, with or without reason at the discretion of the Facility. No employee of Edison can enter into an employment contract for a specified period of time, or make any agreement contrary to this policy without the written approval of Executive Director.

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

NAME: _____

DATE: _____

EMPLOYEE SIGNATURE: _____

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MEDICAL INSURANCE WAIVER

AFTER 90 DAYS OF EMPLOYMENT:

I certify that I have been given an opportunity to participate in the health insurance plan offered by Edison Home Health Care and I am refusing the coverage. I understand that I will not be allowed to enroll in Edison's group health plans past 90 days of employment, during the plan year, unless I experience a qualifying election change event.

_____

EMPLOYEE'S NAME (print)

_____ _____

EMPLOYEE SIGNATURE **DATE**