ELECTRONIC SIGNATURE

PLEASE READ AND ACCEPT THE FOLLOWING STATEMENT BY SIGNING BELOW.

I UNDERSTAND AND AGREE THAT MY APPLICATION WILL BE SIGNED ELECTRONICALLY WHEN I SIGN BELOW. I ALSO UNDERSTAND THAT MY ELECTRONIC SIGNATURE MEANS THAT I INTEND TO APPLY FOR A POSITION WITH SIGNAL HEALTH GROUP AND ALL OF THE INFORMATION I HAVE PROVIDED AND SIGNED OFF ON IS TRUE AND ACCURATE.

I DECLARE UNDER PENALTY OF PERJURY THAT I HAVE EXAMINED ALL OF THE INFORMATION ON THIS APPLICATION AND HR PAPERWORK, AND IT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANYONE WHO KNOWINGLY GIVES A FALSE OR MISLEADING STATEMENT ABOUT A MATERIAL FACT IN THIS APPLICATION, OR CAUSES SOMEONE ELSE TO DO SO, COMMITS A CRIME AND MAY BE SUBJECT TO PRISON TIME, PENALTIES, OR BOTH.

_____

EMPLOYEE PRINTED NAME

_____ _____

EMPLOYEE'S PHYSICAL SIGNATURE DATE

_____ _____

WITNESS DATE

ORIENTATION INSTRUCTION PAGE SIGN OFF FOR ALL EMPLOYEES

Signal Health Group Inc. uses a unique method to orient its new employees so that we are assured that every employee receives ALL the information needed on your hiring date.

We ask that you have the complete hiring packet and your job description prior to starting the exercise.

As you go through the packet, each document will be reviewed. You should have the document being reviewed in front of you and you should read through it as we proceed. As we finish each document you will sign and date each document and put it aside in the order we go through.

Use care on the document marked "Reference Request". We require you to provide 2 written references in your file. Fill in the name of the company or person **and their address** that you would like us to send the reference request to (at the top of the document). If you don't know the addresses during orientation please find it out as soon as you leave today and call us before the day is over.

The section called "Orientation for All Employees" and the document called "Orientation for Direct Care Employees" are in a table format. As we complete each section, you will put today's date and your initials in the right hand column indicating that you had that section reviewed with you.

Please inform us right away if you suspect that something negative will come back on your Criminal Background Check. Not all convictions will eliminate you from working in homecare but you must understand that we are responsible for assuring the safety of vulnerable patients (elderly and children). Speak to the Administrator privately if you suspect a problem will be identified.

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

Please have your documents ready for copy before Orientation begins:
Driver's license, social security card, legal immigration documents (if applicable), current professional license, copy of professional liability insurance, Home Health Aide certificate, TB test results within the past 12 months, and HHA in-service record for the current year.

_____	_____	_____	_____
EMPLOYEE SIGNATURE	DATE	ORIENTATION PERFORMED BY	DATE

ACKNOWLEDGMENT EMPLOYEE HANDBOOK / DOS & DON'TS

Signal Health Group Inc.

Listed are some pertinent references to employee policies from the Agency Employee Handbook. For more detailed information please refer to the Handbook. You may request to review any/all of the personnel policies pertinent to your employment at our Agency at any time.

1. Do wear scrubs to all your visits.
2. Do wear your Agency issued photo ID badge at all time when on agency business.
3. Do arrive on time for ALL assignments. Our Agency must be notified immediately if:
    a. An emergency or situation arises which causes you to be late by five or more minutes.
    b. You will be absent from your assignment.

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

4. Once you have been given an assignment, no more than 2 cancellations will be tolerated.
5. Don't use the patient's phone. Cell phones are off during all visits.
6. Under NO circumstances should you ever take property, money or "borrow" anything that belongs to a patient or ever enter into any type of legal or financial agreement.
7. Don't discuss your rate of pay with your patients or any other employee of the Agency.
8. Do complete visit notes correctly and completely and have signed by the patient AT THE TIME OF THE VISIT.
9. Do call our coordinator to see if there are cases to be covered if you are not scheduled for work.
10. If any problem arises on your assignment, you must call the office immediately.
11. Do call the office immediately if the patient does not answer the door for a scheduled visit. Failure to notify the office may be considered abandonment, especially if the patient has had a medical emergency and is on the floor in need of medical assistance. DON'T assume they aren't home. CALL THE OFFICE.
12. Don't leave any assignment early without first calling your scheduling coordinator immediately.
13. Do report any incident/accident or unusual occurrence involving a Signal Health Group Inc. employee/patient must be reported to our office **immediately**. If you are injured and unable to make the call have one of your family call us right away.
14. Do follow your schedule at all times WITHOUT MAKING ANY CHANGES.
15. Don't transport a patient's in your car unless you have a signed consent/authorization.
16. Drug testing is up to management discretion.
17. Cancellation Policy: A minimum of four (4) hours cancellation notice must be given at all times, unless you are involved in an emergency. Sick call shall be made with a 2 hour notice. Should you decide an assigned patient must be removed from your schedule, the office requires a minimum of one week's notice to arrange a change of worker. 2 weeks' notice is preferred.

My signature acknowledges that I have received and have read the Employee Handbook and agree to the Agency's Dos & Don'ts as listed above & in the Handbook.

_____ _____

EMPLOYEE SIGNATURE DATE

CONFIDENTIALITY AGREEMENT

This agreement is made between _____ (the "Employee") and Signal Health Group Inc., (the "Employer") on the ___ of _____, 20___.

The Employee agrees to the terms of this Agreement:

1.) As a condition of employment, the Employer requires that all new Employees agree to enter into this Confidentiality Agreement (the Agreement). The Employee acknowledges that employment with Employer is sufficient consideration for the Employee to entering into the Agreement.
2.) The Employee acknowledges that, in the course of employment, the Employee will, and may in the future, come into possession of certain confidential information belonging to the Employer including but not limited to trade secrets, data, materials, products, technology, computer programs, specifications, manuals, business plans, software, marketing plans, financial information, and other information disclosed or submitted. This confidential information may be embodied in hand written notes by the Employee, computer disks, tapes, paper, or any other media.
3.) The Employee hereby covenants and agrees that she or he will at no time, during or after the term of employment with the Employer, use for his or her own benefit or the benefit of others, or discloses or divulge to others, any such confidential information.
4.) Upon termination of employment, the Employee will return, retaining no copies or notes, all documents relating to the Employer's business including, but not limited to, reports, lists, correspondence, information, computer files, computer disks, and all other material and all copies of such material, obtained by the Employee during employment nor will the Employee attempt to contact or solicit any patients that the Employee may have worked with during employment.
5.) The Employee recognizes that the Employer may be irreparably damaged by breach of this Agreement and that the Employer shall be entitled to seek an injunction to prevent such competition or disclosure, and will entitle the Employer to other legal remedies, including attorney's fees and costs.
6.) The obligations of Recipient herein shall be effective from the date Owner last discloses any Confidential Information to Recipient pursuant to this Agreement.
7.) If any part of this Agreement is adjudged invalid, illegal or unenforceable, the remaining parts shall not be affected and shall remain in full force and effect.
8.) This instrument, including any attached exhibits and addenda, constitutes the entire Agreement of the parties. No representation or promises have been made except those that are set out in this Agreement. This Agreement may not be modified except in writing signed by all parties.
9.) This agreement shall take effect as a sealed instrument and shall be construed, governed and enforced in accordance with the laws of the State of Indiana, without regards to its conflicts of law provisions.
10.) The descriptive headings used herein are for convenience of reference only and they are not intended to have any effect whatsoever in determining the rights or obligations under this agreement.

EMPLOYEE:	**EMPLOYER:**
_____	_____
SIGNATURE	SIGNATURE
_____	_____
TITLE	TITLE
_____	_____
DATE	DATE

ALL EMPLOYEE/CONTRACTORS SIGN OFFS

_____ INITIAL **Employee Sign Off Regarding HIPAA Privacy**

I have read and understand this policy on Protected Health Information (PHI) and security. I understand that should any situation arise where I breach patient privacy I will be disciplined up to and including termination. I hereby agree to maintain patient confidentiality in the strictest manner possible, sharing or discussing patient information only with those designated care providers or supervisors who have "a need to know" and are actively involved in the care of services provided to the patients. I further acknowledge that I have been trained in the provisions and laws related to HIPAA compliance during orientation and those patients must sign written permission to allow their health information (PHI) to be disclosed. I further agree that I will protect PHI while servicing patients and will not allow any PHI to be visible anytime; I will not bring any PHI related to another patient into the setting of patients I am servicing.

____ INITIAL **Corporate Compliance Employee Sign Off**

Our Agency is committed to providing the highest ethical health care and upholding conduct standards and corporate legal compliance. Our policies and Corporate Compliance Plan clearly support a 'zero' tolerance to any form of fraud or misconduct. This applies to all employees, direct and contracted, regardless of position or title. I, as an Employee of the Agency, acknowledge that I have 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.

_____ INITIAL **Incident/Accidents Reporting Acknowledgement**

I have been thoroughly informed by the Agency that I **MUST** report **ALL** incidents/accidents and any medical, physical, or mental changes in my Members **immediately** to the Supervisor/office. I further understand that in the event that I become injured, even a minor injury, I am required to report that incident to my office as soon as possible after an injury.

OUR AGENCY IS AVAILABLE BY PHONE 24 HOURS A DAY. THE ANSWERING SERVICE WILL RESPOND AFTER 5 PM WEEKDAYS AND ON WEEKENDS/HOLIDAYS

_____ INITIAL **Acknowledgement/Understanding of Zero Tolerance Sexual Abuse Policy**

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

_____ INITIAL **Fraud/False Claims Laws/ Whistleblower Protection Policy Acknowledgement**

I have received & reviewed the Agency policy on Fraud as part of my hire packet.

EMPLOYEE SIGNATURE:

DATE:

CONFLICT OF INTEREST

POLICY:
No employee or member of the Governing Body, Advisory Committee, or other individual, committee, or entity shall derive any profit or gain directly or indirectly by reason of their association with the agency, without the prior knowledge and approval of the Governing Body. All board members and/or employees, at the discretion and specific request of the board, will be required to submit a disclosure statement annually.

If a matter arises in which a member of the board or employee has a conflict of interest, it shall be promptly disclosed to the Administrator and Governing Body.

In matters involving a conflict of interest, a board member must disclose any known significant reasons why a transaction might not be in the best interest of the agency and a board member shall not participate in discussions unless requested by the board nor vote on such transactions. The abstention and the reason for it shall be recorded in the minutes.

Field staff in any capacity understands that all patients are patients of the Agency not personal patients of the field staff. Patients may never be serviced privately by an employee of Our Agency for the financial gain of the employee. Should an employee terminate employment with Signal Health Group Inc., the field staff understands that the patient may not be encouraged or otherwise moved from our Agency to another agency.

INDIVIDUAL STATEMENT REGARDING CONFLICT OF INTEREST.

I, _____, have read and am fully familiar with the agency's policy statement regarding conflict of interest. I am not presently involved in any transaction, investment, or other matter in which I would profit or gain directly or indirectly as a result of my membership on the Agency's Governing Body or its committees or my employment.

Furthermore, I agree to disclose any such interest which may occur in accordance with the requirements of the policy and agree to abstain from any vote or action regarding the agency's business that might result in any profit or gain directly or indirectly, for myself.

I also work for another homecare agency: ☐ YES ☐ NO

I am disclosing the name of the agency/agencies: _____

_____ _____

SIGNATURE DATE

NON-DISCRIMINATION/LEP STATEMENT

Signal Health Group Inc. complies with applicable Federal civil rights laws and does not discriminate in hiring or admissions, on the basis of race, color, national origin, age, disability, or sex. Our Agency does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Signal Health Group Inc.:

- Provides free aids and services to patients with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language services to patients whose primary language is not English (LEP) such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact the Agency.

If you believe that Signal Health Group Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Agency Name: Signal Health Group Inc.
Agency Civil Rights Coordinator: Administrator
Agency Address: 2013 Chester Blvd, Richmond, IN 47374
Agency Phone: 800-260-6145

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Agency is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:
U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F
HHH Building, 1-800-368-1019, 800-537-7697 (TDD)

_____ _____

EMPLOYEE SIGNATURE DATE

ABSENCE AND TARDINESS

POLICY

Regular attendance is required of all employees for the Agency to operate smoothly. Excessive tardiness and/or absenteeism will result in disciplinary action up to and including termination.

GUIDELINES

- Employees are expected to be at their work site and ready to work at the start of their assigned work hours. Employees are expected to remain at their job site until the end of their assigned work hours.

- Employee that is unable to report to work, must notify their supervisor at least 4 hours prior to the start of their shift. Employee will call 800-260-6145 (IN) or 702-843-0579 (NV) to reach supervisor or leave a message for the supervisor.

- Employee that will be tardy arriving to the job site is required to call their supervisor to report tardiness and expected time of arrival. Employee will call 800-260-6145 (IN) or 702-843-0579 (NV) to reach supervisor or leave a message for the supervisor.

- Absences and tardiness will be documented and monitored by the scheduling department. The disciplinary policy shall be used following the guidelines listed below

    - 3 issues of tardiness in 30 days will result in a Verbal Warning. If tardiness continues, a Written Warning will be issued. In the event the tardiness still continues, a review of employee record will be completed by the Supervisor and HR to determine if 2nd Written Warning or termination of employment will apply.
    - 3 or more call-ins within 90 days will result in a Verbal Warning. Should call-ins continue, a written warning will be issued. In the event call-ins continue, a review of employee record will be completed by the Supervisor and HR to determine if a 2nd Written Warning or termination of employment will apply.

_____ _____

Employee Signature Date

_____ _____

Agency Representative Date

Agency Smoking Policy

INTRODUCTION

We are committed to providing a safe and healthy workplace and to promoting the health and wellbeing of it's employees. As required by the State Department of Health and also motivated by our desire to provide a healthy work environment for our employees, the following smoking policy has been adopted and shall apply to all employees of this agency.

POLICY

It is the policy of this agency to prohibit smoking on all company premises in order to provide and maintain a safe and healthy work environment for all employees. The law defines smoking as the "act of lighting, smoking or carrying a lit or smoldering cigar, cigarette or pipe of any kind."

SCOPE

The smoke – free workplace policy applies to:

- All areas of the buildings occupied by company employees.
- All company-sponsored off-site conferences and meetings.
- All vehicles owned or leased by the company.
- All customers to company premises.
- All contractors and consultants and/or their employees working on company premises.
- All temporary employees.
- All student interns.

PROCEDURES

We believe that the spirit of thoughtfulness and cooperation which is characteristic at the company is adequate to resolve any disputes which might arise under this policy. Where disputes cannot be so resolved, the rights of the nonsmoker shall be given precedence, as required by the State.

Employees who violate this smoking policy will be subject to disciplinary action up to and including immediate discharge.

RESOLVING COMPLAINTS ABOUT SMOKING

Any complaints about the application of the policy to the workplace should be brought to the attention of the HR Manager or your superior.

The complaint should be submitted in writing and identify specific objections. The agency will investigate the complaint and resolve it in accordance with the policy.

No employee shall suffer any form of retaliation for raising a complaint or asking a question about this policy.

Our smoking policy is intended to comply with requirements of the State Department of Health.

STATEMENT OF UNDERSTANDING

I have read and fully understand the terms of this policy. I understand that any violation of this smoking policy will be subject to disciplinary action up to and including immediate discharge. I understand that the agency reserves the right to make changes to this policy as may be required.

_____	_____	_____
Employee Print Name	Employee Sign Name	Date

Employee Name_____ Date_____

CELLULAR PHONE USE

Your employer does not permit employees, on company time, to talk or text on your cellular phone while driving a vehicle. This is very dangerous and should be avoided at all times. It is mandatory that you must pull over and stop your vehicle each time you conduct agency business per cellular phone.

The Agency is not responsible for any moving violations, accidents, or any other incidents that may occur while you are using your cellular phone and driving.

CELLULAR PHONE USE DURING PATIENT CARE

Employees are not permitted to use their cellular phone for personal business or recreational use while at the client's home.

By signing below, I have read and understand the above information of the agency regulation regarding cellular phone use and I agree to comply.

Employee Signature_____ Date_____

Agency Rep. Signature_____ Date_____

PHOTO RELEASE

NAME_____DATE_____

I hereby consent and grant Signal Health Group, permission to use my image and likeness in any and all existing and future company-related publications and other media. I will not make any monetary or other claims against Signal Health Group for use of my image and likeness in any forms of media.

SIGNATURE_____DATE_____

AGENCY REP SIGNATURE_____DATE_____