

CL: _____

Strength Within Cell Phone Policy

Employees may carry and use personal cell phones while at work on a sporadic basis. If employee use of a personal cell phone causes disruptions or loss in productivity, the employee may become subject to disciplinary action per Strength Within policy. Personal cell phones shall be used for clocking in and out if necessary, emergency phone calls or text messages on a sporadic basis. Cell phone should not be used for social media, casual conversation, browsing the web non-work-related or personal entertainment.

Strength Within Smoking Policy

Smoking is prohibited on time clock while on job site. Employees are only allowed to have a 10-minute smoke break in their personal vehicles if work shift is 5 hours or more.

Employee: _____

Date: _____

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 protected at all times. 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 for 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 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 protected at all times.

Employee _____

Date: _____

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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: _____

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EMPLOYEE CONFIDENTIALITY AGREEMENT of PATIENT HEALTH INFORMATION AND PERSONAL INFORMATION in accordance with HIPAA REGULATIONS.

(employee), the undersigned Employee hereby agrees not to

Agency

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 | | |

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Employee Signature _____

Date _____

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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 that 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 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_____

The ability to drive and the ability to access clients' homes which may not be routinely wheelchair accessible are required.	
Hearing, eyesight and physical dexterity must be sufficient to perform a physical assessment of the client's condition and to perform client care/services	
On occasion, may be required to bend, stoop, reach and move client weight up to 250 pounds; lift and/or carry up to 30 pounds.	
Must be able to communicate clearly, both verbally and in writing.	
EQUIPMENT OPERATION	
Use of BP cuff, thermometer and stethoscope Hand washing materials.	
COMPANY INFORMATION	
Has access to all client medical records which may be discussed with the Registered Nurse	
QUALIFICATIONS	
Completion of at least the ninth grade. Preferably a high school diploma or equivalent	
Must have completed a minimum of 40 hours of training which includes an introduction to personal care services	
Must be free from health problems that may be injurious to client, self and co-workers and must present appropriate evidence to substantiate this	
Must comprehend the basics of personal care, housekeeping and meal preparation	
Must understand and respect client's including ethics and confidentiality of care	
Must be able to understand, read and write English.	
ACKNOWLEDGMENT	
Employee Signature	Date

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TITLE OF POSITION: PERSONAL CARE WORKER/HOMEMAKER

TITLE OF IMMEDIATE SUPERVISOR: SUPERVISING NURSE

RISK OF EXPOSURE TO BLOODBORNE PATHOGENS – HIGH

POSITION RESPONSIBILITIES

Follows the plan of care to help the client to maintain good personal hygiene and maintain a healthful, safe environment, is to perform ONLY those functions specified for each individual client

Receives written instructions from the supervisor

Has knowledge of Agency policies and procedures

Is trained in first aid.

Is oriented and trained in all aspects of care to be provided to clients.

If able to demonstrate competency in all areas of training for personal care

Personal Care Aides may assist clients with the following activities;

- a. Self-administration of medications by reminding the client to take medications and opening containers for the client
- b. Housekeeping
- c. Personal grooming and dressing
- d. Eating and meal preparation
- e. Oral hygiene and denture care
- f. Toileting and toilet hygiene
- g. Arranging for medical and dental care including transportation to and from the appointment
- h. taking and recording oral temperatures
- i. Administering emergency first aid
- j. Providing or arranging for social interaction
- k. Providing transportation

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Reports any change in the client's mental or physical condition or in the home situation to his/her immediate supervisor, the staff nurse, or to the Home Care Aide supervisor

JOB CONDITIONS

Request for Taxpayer Identification Number and Certification

Give Form to the
requester. Do not
send to the IRS.

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type.
See Specific Instructions on page 3.

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. ☐ Individual/sole proprietor or single-member LLC ☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. ☐ Other (see instructions) ► _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ (Applies to accounts maintained outside the U.S.)
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) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

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.

Social security number	
	- -
or	
Employer identification number	
	-

Part II 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.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding 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 for Part II, later.

Sign
Here

Signature of
U.S. person ►

Date ►

General Instructions

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

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 (interest earned or paid)

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



Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS

Form I-9

OMB No. 1615-0047

Expires 03/31/2016

▶ **START HERE.** Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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		E-mail Address			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):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (See instructions)
- ☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- ☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date (mm/dd/yyyy):
------------------------	--------------------

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

Signature of Preparer or Translator:		Date (mm/dd/yyyy):		
Last Name (Family Name)		First Name (Given Name)		
Address (Street Number and Name)		City or Town	State	Zip Code



Employer Completes Next Page



Office Only

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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:		3-D Barcode Do Not Write in This Space		
Issuing Authority:				
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		Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name (Family Name)		First Name (Given Name)		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) Last Name (Family Name) First Name (Given Name) Middle Initial B. Date of Rehire (if applicable) (mm/dd/yyyy):

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
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Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____

The diagram shows a check with the following details:

- Payee: John Jones, 124 Main Street, Anywhere, MA 02345
- Pay to the order of: _____
- Amount: \$ _____ Dollars
- Routing Number: 123456789 (labeled "9 digit Routing Number")
- Account Number: 1234567891011 (labeled "Account Number (1-17 digits)")
- Check Number: 0259 (labeled "Check Number (do not include)")

Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Type of Account: Checking Savings (Circle One)

Please attach a voided check for each bank account to which funds should be deposited.

Strength Within LLC is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____

JOB ACCEPTANCE STATEMENT

I have read, understand and agree to the terms specified in this job description for the position I presently hold. A copy of this job description has been given to me.

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 _____

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DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____, acknowledge that a Computerized Criminal

APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB identifiers I supply. (This is not a consent form.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history, therefore the organization conducting the criminal history check is not allowed to discuss with me any criminal history record information obtained using this method. The agency may request that I have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search. Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

In order to complete the process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at [www.txdps.state.tx.us /Crime Records/Review of Personal Criminal History](http://www.txdps.state.tx.us/CrimeRecords/ReviewofPersonalCriminalHistory) or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of \$24.95 to the fingerprinting services company.

(This copy must remain on file by your agency. Required for future DPS Audits)

Signature of Applicant or Employee

Date

Agency Name (Please print)

Agency Representative Name (Please print)

Signature of Agency Representative

Date

Please:	
Check and initial each Applicable Space	
CCH Report Printed:	
YES _____ NO _____	_____ initial
Purpose of CCH:	_____
Empl _____ Vol/Contractor _____	_____ initial
Date Printed: _____	_____ initial
Destroyed Date: _____	_____ initial
Retain in your files	

HHSC Compensation Acknowledgement

The rules and regulations of the Texas Department of Health and Human Service state as of 09/01/2025 that Strength Within LLC is required to compensate all employees/contractors at a minimum rate of \$10.60 per hour

I hereby acknowledge, I _____, will be compensated within the regulations of the Texas Department of Aging and Disability Service.

Strength Within approve attendant hourly wage of _____ (office use only)

Signature: Date: