EDISON
HOME HEALTH CARE

NO CONFLICT ATTESTATION

In order to qualify to act as the Personal Assistant for this Consumer, I attest to the ALL of following:

1. I am NOT the Consumer's Designated Representative.
2. The Consumer is NOT my child who is under 21 years of age.
3. I am NOT the Consumer's spouse.

Do you live at the same address as the Consumer? ☐ Yes ☐ No

If I answer YES to ANY of the 3 points listed above, I understand that I CANNOT act as the Personal Assistant for this Consumer and that any attempt to do so, would be considered a violation of this CDPAP agreement and an act of fraud.

In addition, I attest to understanding that my employer is the Consumer and not Edison Home Health Care.

Personal Assistant Name: _____

Personal Assistant Signature: _____ Date: _____

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For Office Use Only:
DATE OF HIRE: _____

Employment Application
CDPAP

Last Name: _____ First: _____ Middle initial: _____

Address: _____Apt #_____ City_____ State_____ Zip code _____

Home Phone Number: _____ Cell Phone Number: _____

anguages: _____

Country of Birth: _____

Ethnicity: _____

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: _____

Education:	Do you have a High School Diploma:	Yes ☐	No ☐
Training:	Do you have a HHA Certificate?	Yes ☐	No ☐
	Do you have a PCA Certificate?	Yes ☐	No ☐

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 employment 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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EMERGENCY CONTACT FORM

Employee Name: _____

First Contact Information

Contact Name: _____

Relationship to Employee: _____

Emergency Contact Home Phone#: _____

Emergency Contact Cell Phone #: _____

***

Second Contact Information

Contact Name: _____

Relationship to Employee: _____

Emergency Contact Phone Home #: _____

Emergency Contact Cell Phone #: _____

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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 (Please print)

_____ _____
Employee's Signature Date

Agreement between Edison Home Health Care and Personal Assistant Live-In

1. All personal assistants (PA's) assigned to live-in cases are to be present in the consumer home for 24 hours each working day.
2. During each live in day, based on a 13 hour day, PA's are to perform tasks in accordance with the verbal or written care plan. PA's may not work in excess of 13 hours in any day and no more than 5 Live in days per week
3. During each 24 hour day, PA's are to take eleven hours for personal time which will include hours of sleep, meal breaks and other personal time, remaining on premises at all such times.
    - 8 hours of sleep time
    - 2 hours meal breaks
    - 1 hours of personal time- reading, watching television, etc.

4. If any PA finds it impossible to take the specified breaks from work duties because such times are constantly interrupted by the needs of the patient, she/he must call the administrator and Edison Home Health Care.

I understand and will abide by the agency's rules stated in this agreement regarding time worked on live- in cases.

_____

Signature

_____

Print Name

_____

Date

EDISON
HOME HEALTH CARE

THE PERSONAL ASSISTANT'S GUIDE TO THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT

I have received the Personal Assistant's guide and I have chosen to participate in the CDPAP as a Personal Assistant. I understand that *Edison Home Health Care* is the fiscal intermediary and I am hired, supervised, scheduled and trained by the consumer and/or designated representative.

Print Name: _____

Signature: _____ **Date:** _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of an *Edison Home Health Care* Notice of Privacy Practices that provides a description of protected information uses and disclosures, and that I have had an opportunity to ask questions about anything that I did not understand.

Signature: _____

Print Name: _____

Date: _____

Personal Assistant Transportation

I will provide *Edison Home Health Care* with my driver's license and insurance card in order to transport my patient in my car and/or the patient's car.

_____ _____

Personal Assistant Signature **Date**

OR

I will not be transporting my patient in my car and/or my patient's car.

_____ _____

Personal Assistant Signature **Date**

I, _____, acknowledge that I will not be able to start working as a Personal Assistant for the CDPAP program until I am specifically informed by Edison Home Health Care that I am able to begin working on the case. Any allowance to work, that does not come directly from Edison, will be considered invalid. If I work under an invalid authorization I realize that I will not be able to be paid by Edison for the time that I worked. I understand that, generally, instructions to begin working as a Personal Assistant will be provided to me along with a caregiver code and an explanation of the process for clocking in and out.

Signature: _____