NATIONS PIONEER HEALTH SERVICES, INC

https://nationspioneer.com | *Email*: **info@nationspioneer.com** | *Tel*: **281-498-6203**

Job Application

We are an Equal Opportunity Employer and committed to excellence through diversity.

The application must be fully completed to be considered. Please complete each section, even if you attach a Resume.

Reset Print Email

Section 1: APPLICATION

Personal Information

Name: Last	First	Middle	Social Security #	DOB

Address	City	State	Zip

Phone number	Email address
	JOHN@GMAIL.COM

Are you legally eligible to work in the US?	Are you a Veteran?	Are you 18 years or older
Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

If selected for employment, are you willing to submit to a background check?

Yes ◯ No ◯

Position

Position you are applying for	Available start date	Desired pay
ATTENDANT		

Employment desired: Part time ◯ Seasonal/Temporary ◯

Education

School name	Location	Years attended	Degree/Certificate	Major

Employment History (start with last first)

Employer (1)	Job title		Dates employed
Work phone	Starting pay rate		Ending pay rate
Address	City	State	Zip
Employer (2)	Job title		Dates employed
Work phone	Starting pay rate		Ending pay rate
Address	City	State	Zip
Employer (3)	Job title		Dates employed
Work phone	Starting pay rate		Ending pay rate
Address	City	State	Zip

References (business and professional only)

Name	Company/Address	Phone	Years Acquainted

Section 2: JOB DESCRIPTION

ATTENDANT-PROVIDER

QUALIFICATIONS:

- Must be at least 18 years of age
- Have a sympathetic attitude towards the care of the client
- Be able to read, write, and comprehend English
- Be able to carry out directions
- Show a high level of maturity and be able to deal effectively with the demands of the job
- Not be listed in the Employee Misconduct Registry or the Nurse Aide Registry
- Not have been convicted of an unemployable felony or misdemeanor during a Criminal History Check

RESPONSIBILITIES:

- Provides safe and effective personal care to the assigned clients.
- Follows Universal Precautions and washes hands before and after the task.
- Completes all work assignments, and accurately performs all assigned responsibilities
- Understands and adheres to established policies and procedures of the Agency (for example, the token device must stay in the individual's home)
- Maintains acceptable attendance status.
- I am willing to accept another client if and, when my current client loses their eligibility, transfer, and/or term with the agency or if the client expires.
- No Call, no show, is not allowed and it can terminate my employment at any time.
- I do not have the right to change my schedule. I do not have the right to keep an individual token device (It is fraud).
- Reports incomplete work assignments to the supervisor.
- Appearance is clean and well-groomed.
- Maintains cleanliness in a work environment.
- Demonstrates sound judgment and decision-making.
- Reports directly to the supervisor.
- Payday is the 10th and 25th of each month

I have read the above job description and fully understand the conditions set forth therein, and if employed as an Attendant – Provider, I will perform these duties to the best of my knowledge and ability. I understand that I will not get paid if I **do not** clock in or out properly through any one of the three (3) devices approved via the Texas HHSC login devices. (Smartphone, landline phone, or Texas EVV small device). My hours of service are based on the hours properly recorded (logging in and out) in any of the three approved logging-in devices. The compensation of **$11.00** an hour is acceptable if you sign the job description. I acknowledge this is a temporary position and based on the patient's/client's needs. Therefore, whenever I am no longer interested in the job for whatever reason, or the client that hires me does not need my services, I agree to notify the supervisor in writing with the reason.

Employee's name (Print): _____

Date:_____ Signature: _____

PROVIDER/CLIENT INTERPERSONAL RELATIONSHIP POLICIES AND ACKNOWLEDGEMENT

- Nations Pioneer Health Services knows that providers and clients develop a mutual understanding. We are therefore NOT liable for any monetary/personal items loaned/borrowed between the client and provider, and vice versa. Hence under NO CIRCUMSTANCES should there be any monetary/personal items loaned or borrowed between both parties. Our agency will NOT refund or replace any items.
- Attendant is advised to do ONLY tasks as listed on the individual's Service Plan.
- It is forbidden for you to transport your client in your own vehicle to and from places. Our agency is not liable for any accidents that may arise when transporting your client in your own vehicle
- You are allowed to escort your client to and from places, but only through other transportation resources. (For example: Metrolift, Uber, or Lyft)

Employee's name (Print): _____

Signature:_____ Date: _____

Section 3: **CONFIDENTIALITY AGREEMENT**

Confidentiality and Non-Disclosure Agreement

To ensure the Agency is in compliance with the HIPAA regulations and to ensure the protection of Protected Health Information (PHI) and the prevention of unauthorized use the Agency will authorize those persons allowed to have access to PHI. The Agency must also ensure that what PHI is used by such authorized persons must be what is minimally necessary to perform / carry out the job duty / function.

By signing this agreement, I agree to comply with the Agency's policies and procedures pertaining to PHI. Failure to do so will result in progressive disciplinary action including termination as applicable.

_____	_____
Date	Authorized Person
_____	_____
Date	Agency Representative

Section 4:
POLICY MANUAL ORIENTATION/ EMPLOYEE COMPLIANCE

4.57 - EMPLOYEE POLICIES AND PROCEDURES / POLICY MANUAL ORIENTATION

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 am 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 in-service training. Home health aides are required to have 12 hours of in-service 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 of venereal disease; testing, results of known infection by HIV, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug of 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 of 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 of vacation leave balance, I authorize the Agency to deduct any amount from my pay- check (s) to correct my accrued or earned sick or vacation leave balance.

_____ _____

Employee Signature Date

Personnel 04.09 Form: **EMPLOYEE COMPLIANCE/ ACKNOWLEDGEMENT FORM**

The employee handbook describes important information about Nation's Pioneer Health service, Inc. and I understand that I should consult the Human Resource Department regarding any questions not answered in the handbook. I have entered my employment relationship with Nations Pioneer Health services, Inc., voluntarily and acknowledge that there is no specified length of employment. Accordingly, either I or Nations Pioneer Health Services, Inc. can terminate the relationship at will, with or without cause, at any time, so long as there is no violation of applicable federal or state law.

Since the information, policies and benefits escribed here are necessarily subject to change, I acknowledge that revisions to the handbook may occur, communicated through official notices, and I understand that revised information may supersede, modify, or eliminate exiting policies. Only the administrator of Nations Pioneer Health Services, Inc. has the ability to adopt any revisions to the policies in this handbook.

Furthermore, I acknowledge that this handbook is neither a contract of employment nor a legal document. I have received the handbook, and I understand that it is my responsibility to read and comply with the policies contained in this handbook and any revisions made to it.

EMPLOYEE'S NAME (PRINT): _____

EMPLOYEE'S SIGNATURE: _____

DATE: _____

Section 5:
DISCIPLINARY ACTION AND EMPLOYEE COUNSELLING

Personnel 04.23: **DISCIPLINARY ACTION AND EMPLOYEE COUNSELING**

POLICY:

The Agency recognizes the value of its employees and strives to provide appropriate training and counseling in order to retain qualified staff. If, however, the employee's supervisor determines that an employee has not maintained acceptable performance or has violated Agency policy, the employee may receive counseling by his/her supervisor the Director of Clinical Services or the Administrator. If during the counseling sessions the employee perceives that a problem has occurred with the process, the employee may discuss the problem with the Director of Clinical Services or the Administrator.

PROCEDURE:

1. The Director of Clinical Services or the Administrator are responsible for ensuring that all Agency policies and statutory requirements are observed.

2. Depending on the situation, the Director of Clinical Services or the Administrator will be present for the counseling session and involved in the formulation of the Employee Counseling Statement. The counseling session, including documentation, must include a definitive plan for correcting the action and a time frame in which this is to be accomplished. The Employee Counseling Statement must be signed by the supervisor and employee and reviewed by the Director of Clinical Services or the Administrator.

3. The Director of Clinical Services or the Administrator will assist in the monitoring of the plan of corrective action and advise the supervisor, when necessary, of any problem areas.

4. The Director of Clinical Services or the Administrator will be available to the supervisor or employee in the event of a disagreement pertaining to the counseling or the plan of correction. If the disagreement cannot be solved, the employee may appeal in writing to the Administrator within one week.

5. The Director of Clinical Services or the Administrator will prepare a summary report and have the employee sign the report.

6. The Administrator will review all the information and discuss the issue with all involved.

Employee Signature _____ Date _____

Section 6: CRIMINAL HISTORY BACKGROUND CHECK

Personnel Section 04.06 Form: **Criminal History Check, Employee Misconduct Registry, Nurse Aide Registry Notification and Statement of Employability**

By execution of this document, I acknowledge that I have been informed by the Agency that a criminal history check will be performed on my name. I have informed this Agency of all names (for example, maiden name, aliases) that I have used in the past. I understand that I have been employed on an emergency basis and that my employment is temporary pending the results of the criminal history check. I also understand that if I have been convicted of the following offenses, that I may not be employed by this Agency. I also understand that the Agency will search the Employee Misconduct Registry and the Nurse Aide Registry (if applicable) to determine whether any acts of abuse, neglect or exploitation has occurred and whether my name is designated on either registry. If my name is designated on either registry, I understand the Agency must deny me employment.

A. I have not been convicted of the following crimes:

- An offense under Chapter 19, Penal Code (criminal homicide)
- An offense under Chapter 20, Penal Code (kidnapping and unlawful restraint)
- An offense under Section 21.11 Penal Code (indecency with a child)
- An offense under Section 22.011, Penal Code (sexual assault)
- An offense under Section 22.02, Penal Code (aggravated assault)
- An offense under Section 22.04, Penal Code (injury to a child, elderly individual, or disabled individual)
- An offense under Section 22.041, Penal Code (abandoning or endangering child)
- An offense under Section 22.08, Penal Code (aiding suicide)
- An offense under Section 25.031, Penal Code (agreement to abduct from custody)
- An offense under Section 25.08, Penal Code (sale or purchase of a child)
- An offense under Section 28.02, Penal Code (arson)
- An offense under Section 29.02, Penal Code (robbery)
- An offense under Section 29.03, Penal Code (aggravated robbery); or
- An offense under Section 21.08, Penal Code (indecent exposure)
- An offense under Section 21.12, Penal Code (improper relationship between educator and student)
- An offense under Section 21.15, Penal Code (improper photography or visual recording)
- An offense under Section 22.05, Penal Code (deadly conduct)
- An offense under Section 22.021, Penal Code (aggravated sexual assault)
- An offense under Section 22.07, Penal Code (terroristic threat)
- An offense under Section 33.021, Penal Code (online solicitation of a minor)
- An offense under Section 34.02, Penal Code (money laundering)
- An offense under Section 35A.02, Penal Code (Medicaid Fraud)
- An offense under Section 36.06, Penal Code (obstruction or retaliation)
- An offense under Section 42.09, Penal Code (cruelty to livestock animals)
- An offense under Section 42.092, Penal Code (cruelty to non-livestock animals); or
- An offense that the Agency determines to be a contraindication to employment with the consumers the Agency serves.
- A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed in this section.

_____

Employee Initial

B. I have not been convicted of the following crimes within five years of this date:

- An offense under Section 22.01, Penal Code (assault), that is punishable as a Class A misdemeanor or as a felony
- An offense under Section 30.02, Penal Code (Burglary)
- A person convicted of an offense under Chapter 31, Penal Code (theft), that is punishable by a felony
- An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or as a felony
- An offense under Section 32.46, Penal Code (securing execution of a document by deception), that is punishable as a Class A misdemeanor of a felony.
- An offense under Section 37.12, Penal Code (false identification as a police officer); or
- An offense under Section 42.01(a) (7), (8) or (9) Penal Code (disorderly conduct).

I understand that all information obtained by this Agency regarding my criminal history will remain confidential. I certify that the information on this form contains no willful misrepresentation, and that the information is true and complete to the best of my knowledge.

A person convicted of an offense, may not be employed in a position the duties of which involve direct contact with a consumer in a facility before the fifth anniversary of the date of the conviction.
(This requirement only applies to those employees first employed by the facility or Agency on or after September 1, 2001). I understand that all information obtained by this Agency regarding my criminal history will remain confidential.

By signing this form, I certify that the information on this form contains no willful misrepresentation, and that the information is true and complete to the best of my knowledge.

_____ _____

Signature of Applicant Date

_____

Print Name

Section 7: **UNIVERSAL/STANDARD (glove) PRECAUTIONS**

IN-SERVICE TRAINING

I, _____ have attended the In-service on Universal/Standard Precautions and Bloodborne Pathogens and I acknowledged and understand my responsibilities in practicing these precautions for all patients.

_____ _____

Signature of employee Date

_____

Print employee's name

Section 8: **OSHA TRAINING**

I have read the information on the OSHA Bloodborne Pathogens Standard and understand the following information:

1. Exposure Control Plan
2. Universal / Standard Precautions
3. Hepatitis B Immunization Program
4. Post Exposure Evaluation and Follow- up

I have also viewed the video titled “Universal Precautions: AIDS and Hepatitis B Protection for Home Health Care”.

_____	_____
Signature of employee	Date
_____	_____
Print employee name	Supervisor Signature/Date

Section 9: DRUGS AND ALCOHOL TESTING

I, _____,

◯ agree with the Agency to perform Drugs and Alcohol Testing on me, if the Agency suspect me using Drugs and Alcohol.

◯ do not agree the Agency to perform Drugs and Alcohol Testing on me, if the Agency suspects me using Drugs and Alcohol.

It will be the Policy of this Agency that any employee that refused Drugs and Alcohol Testing will be terminated immediately.

_____ _____
Employee's Signature Date

_____ _____
Employer's Signature Date

Abuse, Neglect, and Exploitation of the Patient Home Health Agency Employees and Independent Contractors Acknowledge

To be signed by each agency employees and independent contractors:

☐ On hire

☐ Annually

I _____ on this date _____ affirm that I have read and understand this agency's policy on reporting of Abuse, Neglect, and Exploitation of the Client. I agree to comply with, and be bound by, the policy.

_____ _____

Name of employee/contractor Date

_____

Supervisor Signature and Date

Section 11: **EMERGENCY CONTACT**

Authorization for Criminal History/Background Check

Have you ever been convicted of a crime, excluding misdemeanor and summary offenses, in the past 10 years, which has not been annulled or expunged or sealed by a court?
(A conviction does NOT necessarily disqualify a candidate from employment by Nation Pioneer Health Services Inc.)

YES ◯ NO ◯

If yes, supply information

I authorize Nations Pioneer Health Services, Inc (NPHS) to do criminal history check, if applicable, by regulation

YES ◯ NO ◯

Emergency Contact

In case of Emergency, notify

Name: Last	First	Relationship	
Address	City	State	Zip
Phone number (Primary)	Phone number (Alternative)		

Section 12: **DISCLAIMER**

Signature Disclaimer

"I certify that the information contained in this application are true and complete to the best of my knowledge and understand if employed, falsified statement on this application may be grounds for dismissal. I authorize investigation of all statements contained herein and the references listed above to give you all information concerning my previous employment and any pertinent information they may have. I release all parties from all liability for any damage that may result from furnishing same to you. I understand and agree that, if hired, my employment is for no definite period, and may, regardless of the date of the payment of my wages and salary, may be terminated, by either party, any time without notice and without cause"

Unfortunately, this position does not pay any overtime.

Name (please print)	Signature:
Date	

==========

Do Not Write Below This Line

Interviewed by: _____ Date: _____

Wage: _____ Date Reporting to work: _____

Employer Signature Date

_____ _____

FOR OFFICIAL USE ONLY. DO NOT WRITE BELOW THIS LINE

PERSONNEL FILE CHECKLIST

NAME: _____ POSITON: ATTENDANT

DATE HIRED: _____

- ☐ Application
- ☐ Job Description
- ☐ Confidentiality Agreement
- ☐ Policy Manual Orientation / Employee Compliance
- ☐ Disciplinary Action
- ☐ OSHA Training
- ☐ W-4 Form
- ☐ I-9 Form
- ☐ Universal Precautions
- ☐ Criminal History Check: **Date**: _____
- ☐ HIPPA Training
- ☐ Nurse Aide Registry/Misconduct/ Statement of Employability: **Date**: _____

- ☐ Drug / Alcohol Testing
- ☐ Infection Control
- ☐ Abuse Neglect Exploitation