☐ PCA Choice ☑ PCA Tradition

1821 University Ave W, Suite S-295
Saint Paul, MN 55104
Phone: 651-470-9549 | Fax: 651-493-2930
www.aareliable.com

PLEASE PRINT ALL INFORMATION REQUESTED EXCEPT SIGNATURE

APPLICATION FOR EMPLOYMENT

APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS

PLEASE COMPLETE PAGES 1-4. DATE _____

Name _____
Last First Middle

Present address _____
Number Street City State Zip

How long at the above address? _____ Social Security No. _____ – _____ – _____

Telephone (____) _____

E-mail address _____

Are you 18 years of age, or older? ☐ Yes ☐ No
Are you legally eligible for employment in the United States? ☐ Yes ☐ No

Position applied for (1) Other
Salary desired (2) _____
(Be specific)

Days available to work (indicate AM or PM)
No Pref _____ Thur _____
Mon _____ Fri _____
Tue _____ Sat _____
Wed _____ Sun _____

How many hours can you work weekly? _____ Can you work nights? No

Employment desired ☐ FULL-TIME ☐ PART-TIME ☐ CASUAL

Earliest date available for work? _____ _____

_____

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (Complete mailing address)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School				
College/University				
Other Education/ Training				
Professional Licenses/Certificate				

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PLEASE PRINT ALL INFORMATION REQUESTED EXCEPT SIGNATURE

A&A Reliable Home Health Care, LLC

APPLICATION FOR EMPLOYMENT

DO YOU HAVE A DRIVER'S LICENSE? ☐ Yes ☐ No Document type:

What is your means of transportation to work? _____

Driver's license number _____ State of issue _____ ❑ Operator ❑ Commercial (CDL)

Expiration date _____

Have you had any accidents during the past three years? How many? _____

Have you had any moving violations during the past three years? How Many? _____

Professional References: Please list two references other than relatives or previous employers.

Name _____ Name _____

Position _____ Position _____

Company _____ Company _____

Address _____ Address _____

_____ _____

Telephone (___) _____ Telephone (___) _____

An application form sometimes makes it difficult for an individual to adequately summarize a complete background. Use the space below to summarize any additional information necessary to describe your full qualifications for the specific position for which you are applying.

_____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____

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PLEASE PRINT ALL INFORMATION REQUESTED EXCEPT SIGNATURE	**A&A Reliable Home Health Care, LLC**	

APPLICATION FOR EMPLOYMENT

MILITARY

HAVE YOU EVER BEEN IN THE ARMED FORCES? ❑ Yes ❑ No

ARE YOU NOW A MEMBER OF THE NATIONAL GUARD? ❑ Yes ❑ No

Specialty _____ Date Entered _____ Discharge Date _____

Work Experience Please list your work experience for the **past five years** beginning with your most recent job held. If you were self-employed, give firm name. **Attach additional sheets if necessary.**

Name of employer: Address: City, State, Zip Code: Phone number:	Name of last supervisor	Employment dates	Pay or salary
		From To	Start Final
	Your last job title:		
Reason for leaving (be specific):			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.			

Name of employer: Address: City, State, Zip Code: Phone number:	Name of last supervisor	Employment dates	Pay or salary
		From To	Start Final
	Your Last Job Title:		
Reason for leaving (be specific):			
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.			

May we contact your present employer? ❑ Yes ❑ No

PLEASE READ CAREFULLY

APPLICATION FORM WAIVER

In exchange for the consideration of my job application by **A&A Reliable Home Health Care, LLC** (hereinafter called "the Company"), I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements, and the like as they may exist from time to time, or other Company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of **A&A Reliable Home Health Care LLC**, or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the President /General Manager of the Company. Both the undersigned and **A&A Reliable Home Health Care LLC** may end the employment relationship at any time, without specified notice or reason. If employed, I understand that the Company may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. I hereby give the Company permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release the Company from any liability as a result of such contract.

I also understand that (1) the Company has a drug and alcohol policy that provides for pre-employment testing as well as testing after employment; (2) consent to and compliance with such policy is a condition of my employment; and (3) continued employment is based on the successful passing of testing under such policy. I further understand that continued employment may be based on the successful passing of job-related physical examinations.

I understand that, in connection with the routine processing of my employment application, the Company may request from a consumer reporting agency an investigative consumer report including information as to my credit records. Upon written request from me, the Company, will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act.

I further understand that my employment with the Company shall be probationary for a period of ninety (90) days, and further that at any time during the probationary period or thereafter, my employment relation with the Company is terminable at will for any reason by either party.

Note: A minimum of two weeks notice is required for resignation from employment

A&A Reliable Home Health Care, LLC is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with this Company depends solely on your qualifications.

☐ PCA Choice ☑ PCA Tradition

IF HIRED, I AGREE TO CONFORM TO THE RULES AND REGULATIONS OF THE COMPANY, AND I UNDERSTAND THAT THE COMPANY HAS COMPLETE DISCRETION TO MODIFY SUCH RULES AND REGULATIONS AT ANY TIME, EXCEPT THAT IT WILL NOT MODIFY ITS POLICY OF EMPLOYMENT AT-WILL.

I authorize the Company or its agents to confirm all statements contained in this application and/or resume as it relates to the position I am seeking to the extent permitted by federal, state, and local law. I agree to complete any requisite authorization forms for the background investigation which may be permitted by federal, state, and/or local law. If applicable and allowed by law, I will receive separate written notification regarding the Company's intent to obtain "consumer report."

I authorize and consent to, without reservation, any party or agency contacted by this employer to furnish the above mentioned information. I hereby release, discharge, and hold harmless, to the extent permitted by federal, state, and local law, any party delivering information to the Company or its duly authorized representative pursuant to this authorization from any liability, claims, charges, or causes of action which I may have as a result of the delivery or disclosure of the above requested information. I hereby release from liability the Company and its representative for seeking such information and all other persons, corporations, or organizations furnishing such information. Further, if hired, I authorize the company to provide truthful information concerning my employment to future employers and hold the company harmless for providing such information.

If hired by this Company, I understand that I will be required to provide genuine documentation establishing my identity and eligibility to be legally employed in the United States by this Company. I also understand this Company employs only individuals who are legally eligible to work in the United States.

THIS APPLICATION WILL BE CONSIDERED ACTIVE FOR A MAXIMUM OF SIXTY (60) DAYS. IF YOU WISH TO BE CONSIDERED FOR EMPLOYMENT AFTER THAT TIME, YOU MUST REAPPLY.

I CERTIFY THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED ON THIS APPLICATION IS TRUE, ACCURATE, AND COMPLETE.

DO NOT SIGN UNTIL YOU HAVE READ ALL OF THE INFORMATION CONTAINED IN THE APPLICATION.

_____ _____

Applicant Signature Date

If the applicant is a minor, the foregoing release and consent must be signed by the applicant's parent or legal guardian. Signature by the applicant's parent or legal guardian constitutes acknowledgement by the applicant and the parent or legal guardian that the Company, to the extent permitted by federal, state, and local law, can test the applicant for illegal or controlled substances, conduct inspections of property without notice, and communicate test results to Company personnel who need to know, the applicant, and the applicant's legal guardian.

_____ _____

Parent/Legal Guardian Date

_____ _____

Witness Date

Subject Background Study Requirement

Please note:

1. Entities are **required by state law to verify** that the information provided for the background study is complete and correct by viewing an acceptable form of identification. The background study subject's full name and date of birth must match exactly to the identity document that the subject uses to be fingerprinted and photographed. **If the information does not match exactly, the person cannot be fingerprinted.**
2. It is important to provide a current mailing address for the background study subject because DHS will mail background study notices to the person.
3. Information identified by an asterisk (*) is required. The personal descriptive information is required by the Minnesota Bureau of Criminal Apprehension (BCA) and the Federal Bureau of Investigation (FBI) to conduct fingerprint-based criminal record checks.

Personal and Demographic Information

**** Required***

* First Name:		SSN:	- -
* Middle Name:		* Date of Birth:	/ /
* Last Name:		* Race:	
Suffix:		* Sex:	Selected
		* Eye Color:	
Permanent/Physical Address		* Hair Color:	
* Address Line 1:		* Height:	
Address Line 2:		* Weight:	lbs.
* City:		US Citizen:	☐ Yes ☐ No
* State:		* Place of Birth:	
* ZIP:		Primary Phone:	( ) -
County:		Primary Phone Type:	
		Secondary Phone:	( ) -
Mailing Address:		Secondary Phone Type:	
☐ Same as Permanent Address (if not, enter below)		Email Address:	

Prior Names and Aliases * ☐ The individual reports that they have not been known by any other name		**Prior Addresses** * ☐ The individual reports that they have not lived out of state during the specified time frame	
Prior Names and Aliases, including maiden names, married names, name changes, and any name the person has used or been known by. These are required for the background study to be valid and are required by law.		Prior out-of-state addresses within the last 5 years (if more than two, please list on the back of this sheet)	
1.		1.	
2.			
3.		2.	
4.			

Verify Identity

* Document Type:

* Issuing State/Authority:

* Document Number:

Expiration Date: / /

Caregiver Safety Acknowledgement

☑ No caregiver shall dead-lift in excess of fifty (50) pounds while performing homecare services.

CG Initials: _____

-Should a special request from client be made, all aspects of the particular issue must be brought to the Director prior to any agreement between caregiver and client.

CG Initials: _____

☑ Caregiver must notify the office of any and all unsafe observations made in the care recipient's home. Examples include, but are not limited to the following:

- Any loose carpeting on hardwood, tile or vinyl flooring.
- Any exposed and/or questionable wiring such as worn out extension / lamp cords for any lights and/or appliances.
- Any flammable materials exposed to the elements of the care recipient's home.
- No certified and current fire extinguisher available in the kitchen area of the care recipient's home.
- Please make careful and safety conscious observations to ensure everyone's safety.

CG Initials: _____

Caregiver name: _____

Signature: _____ Date: _____

Agency Director: _____

Signature: _____ Date: _____

Authorization to Release Affiliation Information

Minnesota law states that an individual PCA may not work over 310 hours per month regardless of how many PCA agencies you are affiliated with. Employees will not be paid more than 310 hours per month. Any payments made to an employee that exceeds the 310 hour limit will be treated as overpayment and will be recovered from the employee in accordance with State and/or Federal law.

Check the option that applies:

◯ Yes, I am affiliated with more than one agency. I authorize A&A Reliable Home Health Care, LLC to request information from all other agencies that I am affiliated with.

List agency names and phone numbers below:

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

◯ No, I am not affiliated with any other agencies.

By signing this authorization, I am agreeing to the terms and conditions above. If I fail to inform A&A Reliable Home Care of my affiliations with other agencies on or after my hire dates, I will be responsible of any over-payments.

Print Employee Name: _____ Date: _____

Employee Signature: _____

MHC Staff Signature: _____

Acknowledgment of Receipt of A&A Reliable Home Care, LLC. Employee Handbook

My signature below acknowledged that I have received a copy of A&A Reliable Home Care, Inc.'s Employee Handbook ("Handbook"). Which include policy procedure as follow:

Policy :	Initial
1. Background check policy	
2. Minnesota Home Care Bill of Right	
3. Criminal Background Check Policy	
4. HIPPA Privacy	
5. Access to your personal file	
6. Grievance Policy	
7. Sexual Abuse Policy	
8. PCA and Homemaker Job description	
9. Restrictive Covenant Agreement	
10. HepBFact Sheet	
11. Fair and Accurate Billing Policy and Timesheet Policy	

I have read it and understand the policies and procedures contained in it. I have had an opportunity to ask questions about and discuss the policies with my supervisor.

I have been advised that the purpose of this Handbook is to inform me of the Agency's policies and procedures, and it is not a contract of employment. No promise of job security has heretofore been given to me and there are no promises contained in the Handbook since I am employed AT WILL. Nothing in this Handbook provides any entitlement to me or to any Agency employee, nor is it intended to create contractual obligations of any kind. I understand that the Agency has the right to change any provision of this Handbook at any time and that I will be bound by any such changes.

_____

Printed Name of Applicant or Employee

_____

Signature of Applicant or Employee

_____

Date

A&A Reliable Home Health Care, LLC
CERTIFICATE OF COMPLETION (2 hour in-service)

Employee Name (print): _____ Date: _____

A Guide to Home Care Services Orientation

- Purpose
- Regulation of Home Care Providers
- State Licensure
- Classes of Licenses
- Services Available Through State Regulated Home Care Providers
- Service Agreements / Service Plan
- Home Care Bill of Rights
- Client Protection
- Criminal Disqualification
- Request by Client for Discontinuation of Life Sustaining Treatment
- Confidentiality of Client Information
- Handling of Client Finances and Property
- Complaint Procedure
- Reporting of Maltreatment of Vulnerable Adults and Minors:
    - Who Must Report
    - What to Report
    - When is Reporting Necessary
- Emergency Procedures
- How to use 911

Scheduling

- Employee Work Schedule
- Schedule cancellation notice (24 hours advance notice)
- Vacation/PTO request (two weeks advance notice)
- Dress Code Policy

Time Sheet Requirement Orientation

- Fair and accurate billing policy
- PCA time and activity documentation policy
    - How to fill out time sheets
    - Sample time sheet
    - Time sheet exercise
- Acknowledgement of Fraud Statement

I have been orientated to the above information and have had my questions answered.

_____ _____

Employee Signature **Date**

_____ _____

Orientation Leader Signature **Date**

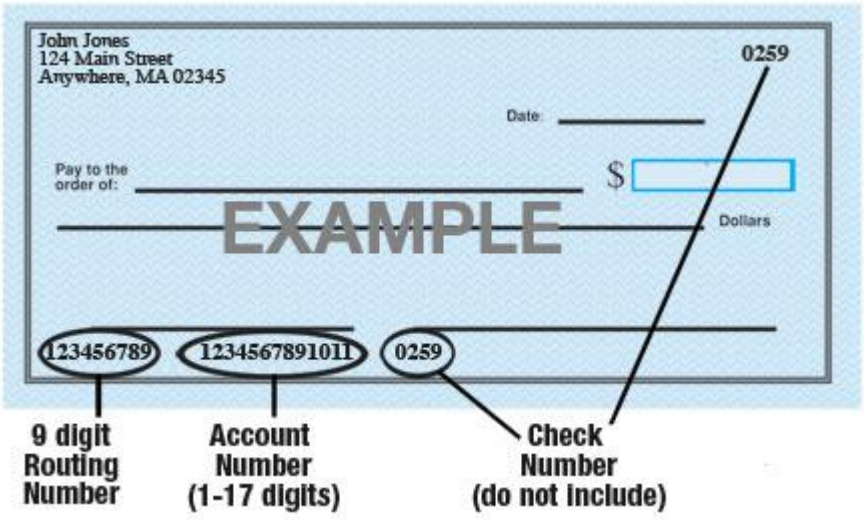
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ $ _____ ☐ _____% or ☐ Entire Paycheck

Type of Account: ☐ Checking ☐ Savings (Circle One)

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

A&A Reliable Home Care 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: _____

DEPARTMENT OF HUMAN SERVICES

DHS-4469-ENG 11-21

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Individual Personal Care Assistant (PCA) Enrollment Application

Complete all fields to enroll an individual personal care assistant or complete your request using the Minnesota Provider Screening and Enrollment (MPSE) portal. If submitting by fax, complete this form online, print and then fax to Minnesota Health Care Programs (MHCP). An incomplete form will delay processing of this application. Check one of the following:

- ◯ New hire (requires new background study and completion of PCA training)
- ◯ Rehire (requires new background study and completion of PCA training) – PREVIOUS EMPLOYMENT END DATE: _____
- ◯ Previous background study conducted for managed care organizations (MCO) (new background study not required)

Individual PCA Information

PROVIDER TYPE **38 - INDIVIDUAL**	**SOCIAL SECURITY NUMBER**	**UMPI** (if requesting reinstatement)
LEGAL NAME (FIRST)	**FULL MIDDLE NAME**	**LAST NAME**
DATE OF BIRTH	**Is the person 18 years old or older?** ◯ Yes ◯ No* *May affiliate with only one agency	PHONE NUMBER
Has this person continued to be employed by your agency or MCO without a break in employment? ◯ Yes ◯ No		

Individual PCA Address

ADDRESS (RESIDENTIAL ADDRESS ONLY – DO NOT ENTER A P.O. BOX)			
CITY	**STATE**	**ZIP CODE**	COUNTY OF RESIDENCE

Individual PCA Training Information

INDIVIDUAL PCA TRAINING COMPLETION DATE	INDIVIDUAL PCA TRAINING CERTIFICATION NUMBER

Individual PCA Background Study Information

BACKGROUND STUDY NUMBER	APPLICATION NUMBER	FACILITY ID 98580

Individual PCA Provider Statement

I have reviewed and certify the information provided on this form is true and correct to the best of my knowledge. **I will notify the MHCP Provider Eligibility and Compliance of any additions or changes to the information.**

By signing this form, I acknowledge I have read and understand the Data Privacy Notice (DHS-6287) (PDF). I also authorize MCHP to use the information you collect about me according to the Privacy Notice.

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

NAME OF INDIVIDUAL PCA (print or type)	**SIGNATURE OF INDIVIDUAL PCA**	**DATE SIGNED**

Organization Affiliation Information

You may affiliate or enroll the individual PCA named on this form if he or she is 18 years old or older with other agencies you directly own without completing another application and agreement. Do you want to affiliate this individual PCA with any other agencies you own? ◯ Yes ◯ No

Organization Information

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

ORGANIZATION OR AGENCY NAME		FACILITY NPI OR UMPI
A&A Reliable Home Health Care, LLC		A084655100
ORGANIZATION FAX NUMBER	ORGANIZATION PERSONNEL COMPLETING FORM	ORGANIZATION PERSONNEL SIGNATURE
651-493-2930		

Next Steps

Read, sign and date the Individual Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement (DHS-4611) (PDF) and return it with this application.

Upload the application and agreement to the Minnesota Provider Screening and Enrollment (MPSE) portal or fax to 651-431-7465. MHCP will process only complete requests.

DEPARTMENT OF HUMAN SERVICES

To: Agency representatives

RE: Individual Personal Care Assistant (PCA) Enrollment Application

As an agency that provides services to Minnesota Health Care Programs (MHCP) members, you must submit this enrollment application and provider agreement for each individual personal care assistant (PCA) provider. When MHCP approves your application we will:

- Assign a Unique Minnesota Provider Identifier (UMPI) to the PCA
- Affiliate the PCA to your agency
- Allow you to bill MHCP for the services the PCA provides to members

To enroll individual PCAs with MHCP, the PCA must:

1. Read and understand the Data Privacy Notice (DHS-6287) (PDF).
2. Complete and pass the Department of Human Services (DHS) background study under each agency facility ID number. The PCA must complete a new background study if he or she has a break from employment with your agency of more than 120 days and then returns.
3. Successfully complete and pass the required PCA training competency test.
4. Complete and sign this application.
5. Read and sign the Individual Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement (DHS-4611) (PDF).

Optional training

The individual PCA may choose to complete the Qualified Enhanced Rate training. Additional information related to enhanced rates and PCA agency responsibilities are on the Enhanced Rate page.

Background study

Complete a background study by logging in to the NETStudy website at: https://bgs.dhs.state.mn.us/a/login.asp. Follow the directions on the NETStudy site.

More information is on the MHCP provider webpage at https://mn.gov/dhs/general-public/background-studies/.

Fax completed forms

MHCP accepts only faxed applications and agreements or submit using the Minnesota Provider Screening and Enrollment (MPSE) portal. If faxing, submit the application and agreement together to 651-431-7465.

DEPARTMENT OF HUMAN SERVICES

DHS-4611-ENG 2-21

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Individual Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement

As a participating provider in Minnesota Health Care Programs (MHCP) administered by the Minnesota Department of Human Services (DHS), the provider agrees to:

A. Submit documentation to your affiliated agency that fully discloses the extent of services provided to individuals under these programs. The documentation must be legible and meet the requirements of Minnesota Statutes, section 256B.0659, subdivision 12 for all individual support workers in Consumer Directed Community Supports (CDCS), Consumer Support Grant (CSG), Personal Care Assistance (PCA), and Community First Services and Supports (CFSS) .

B. Furnish DHS, the secretary of the U.S. Department of Health and Human Services (DHHS), or the Minnesota Medicaid Fraud Control Unit with such information as it may request regarding payments claimed for services provided under these programs.

C. Comply with all federal and state statutes and rules relating to the delivery of services to individuals and to the submission of claims for such services.

D. Accept as payment in full, amounts paid in accordance with schedules established by DHS, except where payment by the member has been authorized by DHS.

E. Make full disclosure of any conviction(s) of program crimes as required by the Code of Federal Regulations, title 42, section 455.106.

F. Comply with all federal statutes, implementing regulations and guidance prohibiting discrimination on the basis of race, color, national origin, sex, age, religion and disability in any program or activity receiving federal financial assistance from DHHS; and to comply with the Minnesota Human Rights Act.

G. Provide services to members of the same scope and quality as would be provided to the general public, within MHCP guidelines.

H. Comply with the provisions of any fully executed agreement or addendum required by DHS, which is incorporated herein by reference.

I. Comply with the advance directive requirements as required by the Code of Federal Regulations, title 42, sections 489.100 and 417.436.

J. Properly handle and safeguard protected information collected, created, used, maintained, or disclosed on behalf of DHS. For purposes of this agreement, “protected information” means data subject to any of the following laws:

1. The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes, chapter 13, section 13.46 ("welfare data");
2. The Minnesota Health Records Act, sections 144.291 and 144.298;
3. The Health Insurance Portability and Accountability Act (“HIPAA”), including but not limited to the requirements of the Privacy Rule and the Security Regulations, the Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E.
4. Federal law and regulations that govern the use and disclosure of substance abuse treatment records, the United States Code, title 42, section 290dd-2 and the Code of Federal Regulations, title 42, sections 2.1 to 2.67; and

Electronic initials accepted.

DIRECT SUPPORT WORKER INITIALS	
NAME OF SUPPORT WORKER	UMPI

5. Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

K. Comply with the laws described in section J. This includes the provider:

1. Not using or further disclosing protected information created, collected, received, stored, used, maintained or disseminated in the course or performance of this agreement other than as necessary to perform its obligations under this Provider Agreement, or as required by law, either during the period of this agreement or after. See, respectively, the Code of Federal Regulations, title 45, sections 164.502(b) and 164.514(d), and Minnesota Statutes, 13.05 subdivision 3.
2. Using appropriate administrative, physical, and technical safeguards to prevent use or disclosure of the protected information other than as provided for by this agreement and to ensure the confidentiality, integrity, and availability of any electronic protected health information (PHI) that it creates, receives, maintains, or transmits on behalf of DHS. The provider will not transmit PHI over the Internet or any other unsecure or open communications channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in the Code of Federal Regulations, title 45, section 164.312. If the provider stores or maintains PHI in encrypted form, the provider shall, at DHS' request, promptly provide DHS with the key or keys to decrypt such information. The provider shall not forward previously encrypted data to any other party, unless otherwise required by this agreement.
3. Mitigating, to the extent practicable, any harmful effects known to the provider of a use, disclosure, or breach of security with respect to protected information by the provider in violation of this agreement.

L. Agree that this agreement may be immediately terminated at the discretion of DHS if it determines that the provider has violated a material term of the agreement, including but not limited to, non-compliance by the provider with the HIPAA Privacy Rule and Security Standards. If termination is not feasible, DHS shall report the breach to the Secretary of DHHS.
Upon termination of this agreement, all of the protected information provided by DHS to the provider, or created or received by the provider on behalf of DHS, that the provider still maintains in any form, including information that is in the hands of subcontractors or agents of the provider, shall be destroyed or returned to DHS, and the provider shall retain no copies of such information. If it is infeasible to return or destroy the information, the provider shall provide DHS notification of the conditions that make return or destruction infeasible, and shall extend the protections of this agreement to such information and limit further use and disclosure of such information to those purposes that make return or destruction infeasible, for as long as the provider maintains the information.

M. Agree that any ambiguity in this agreement shall be resolved to permit DHS to comply with HIPAA, MDGPA, and other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information and other state and federal laws and regulations.

Upon signature, this Provider Agreement supersedes and replaces all former Provider Agreements the provider has with DHS.

An individual applicant must personally sign the Provider Agreement. Sign and date this form, initial page 1, and return both page 1 and page 2 of this agreement.

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

NAME OF SUPPORT WORKER (TYPE OR PRINT)	TITLE Personal Care Assistant
SIGNATURE OF SUPPORT WORKER	DATE

Keep a copy of the Provider Agreement for your files and upload the original form using the online Minnesota Provider Screening and Enrollment (MPSE) portal, or fax to 651-431-7465.

Agreement Summary

As an individual support worker, you are providing health care services to individuals. We require your enrollment in the Minnesota Health Care Programs (MHCP) and to be listed as the rendering provider on the claim so that you are represented as the person who provided the services. Knowing that a qualified individual provided the service ensures the safety of the people that the Minnesota Department of Human Services (DHS) serves. It also allows DHS to perform auditing and tracking of services which protects against double-billing and other types of fraud. Before enrollment is approved, MHCP must make certain that:

1. There is no legal or other reason why you shouldn't provide these services,
2. You understand what is necessary to properly provide these services, and
3. You understand the need to protect the privacy of the people you care for.

To help ensure that each of these conditions is met, MHCP requires that you agree to the terms in the attached Provider Agreement. In general, this agreement requires that you:

A. Provide documents to your employer about the services you provide.

B. Provide documents to MHCP or other state and federal agencies related to the services you provide, when requested.

C. Comply with federal and state laws about the services you provide.

D. Accept payment made to your employer as payment in full for the services you provide. You cannot ask for nor accept additional payment from the member.

E. Disclose any criminal convictions you have related to Medicare, Medicaid, or title XX services.

F. Not discriminate against individuals because of their race, color, national origin, sex, age, religion or disability when you provide these services.

G. Provide the same quality of service to persons receiving public assistance as those who don't receive such assistance.

H. If you are enrolled to provide and bill for other services, you must continue to follow the requirements of the agreement you signed when you enrolled for those services. The terms of that agreement are different than the terms in the attached agreement.

I. Comply with federal requirements about advance directives. An advance directive is written instruction, such as a living will, to give a patient control over medical treatment decisions.

J. Properly protect private information about the people to whom you provide services, especially their health information.

K. Don't disclose the private information of someone for whom you provide services, unless it is needed for your work. This includes not discussing someone's private information unless your job requires it. Also, ensure that the information could not be accessed by someone who does not have permission to see it. This includes not leaving paperwork out where others can see it, and not sending private information over the internet.

L. Understand that this agreement may be canceled if you violate its terms. If this agreement is canceled, you must properly dispose of any private information you have about the people you serve so that it is not discovered by someone who does not have permission to see it.

M. Understand that by signing this agreement, you are agreeing to protect any private information you come in contact with in your job. When you protect private information, you are complying with federal and state laws, and you help DHS comply with these laws, as well.

This is a basic description of the terms of this agreement.

By signing this agreement, you are agreeing to be legally bound by all of its terms. If you have questions about it, you should get answers to them before signing this agreement. If you need or want legal advice, you should contact your own attorney. For more information, call 651-431-2700.

Employee Agreement

Employee Name: _____Employee Position☐PCA ☐HMK☐RN

I am agreeing to an hourly pay rate of $_____ Per Hour, Paid Bi-weekly effective _____ to _____. For all accurate and completed time sheets that are received by A&A Reliable Home Care by the time sheet deadline for the applicable pay period. A State background check has been incurred by the company on your behalf to obtain your required PCA provider number. I understand that if I fail to stay employed with A&A Reliable Home Care for 120 days from my first shift worked, this expense will be deducted from my final paycheck at the rate of $28 for the background study. I understand the first 90 days of employment, starting with my first shift worked, are probationary. Attendance issues will result in termination of your employment. Dependability in home care is critical.

I understand that I am ☐ allowed/ ☐ not allowed to work up to _____ hours over time.

I understand that a "No Call/No Show" or calling in for a shift after it would have begun is a disciplinary action that may include immediate termination and reporting the incident to the Minnesota Certified Nursing Assistant Registry or the Department of Human Services PCA Registry.

I understand that my employment with A&A Reliable Home Care is independent of any client I am working with. Management can place me or re-assign me to other cases as it deems appropriate. I agree to contact the office with any concerns, complaints, or conflicts that may arise during caring for a client.

I understand part of completing any work performed is turning in a completed time-sheet for that work and that in order to guarantee payment for that work, the time-sheet must be submitted within 30 days of the service date. Time submitted more than 30 days after the service date may not be reimbursable.

I understand that MN Statute 256B Subd. 11 prohibits PCA's from working or being paid for more than 310 hours per month as a PCA for PCA recipients, regardless of the number of recipients being served or the number of PCA provider agencies you are enrolled with.

I understand that if I quit my employment with A&A Reliable Home Care, I must give two weeks' notice to A&A Reliable Home Care management. If I quit my employment with A&A Reliable Home Care and if I do not provide two weeks written notice and do not fulfill my scheduled shifts in my

last two weeks of employment, I understand I will have violated this employment contract and my last two weeks of worked hours will then be paid at minimum wage.

I understand timecards must be filled out completely. If any information is not included, I will not be paid until the information is corrected. I understand it is a federal crime to misrepresent time and visits to clients for Medicaid reimbursement. All timecards must be received before 11:59PM on Monday following the end of a pay period to be included on the following week's paycheck. Late timecards will be paid the subsequent pay day. Pay day is every other Friday. You may refer to the pay period schedule for exact deadlines.

I accept this position and agree to the terms outlined.

Signature: _____ Date: _____

MHC Rep. Signature: _____ Date: _____

HEPATITIS B VACCINATION ACCEPTANCE/REFUSAL FORM

Dear Caregiver:
In accordance with OSHA guidelines, Senior Home Living, Inc. is offering at NO COST to you the opportunity to be immunized against potentially infectious Hepatitis B Virus (HBV).

Following you will find a Hepatitis B vaccination acceptance/refusal form. You are not required to accept these vaccinations.

Whether you elect to receive the vaccination (3- injection series) or not, please complete the following (Hepatitis B Vaccination Acceptance/Refusal Form) and return the form to the Director of the Senior Home Living, Inc.

HEPATITIS B VACCINATION ACCEPTANCE/REFUSAL FORM

Name: _____ Position: Caregiver

Address: _____

_____

_____ Phone: _____

Please check one of the following:

☐ I would like to receive the Hepatitis B series of three (3) vaccinations.

☐ I have already received all three (3) Hepatitis B vaccinations.

☐ I decline to receive the Hepatitis B series of three (3) vaccinations, and have read the paragraphs below.

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B infection. I have been offered the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to me. However, I decline the Hepatitis B vaccination at this time.

I also 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 at no charge to me.

Caregiver
Signature: _____ Date: _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ 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 Last 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	Employee's E-mail Address	Employee's 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 boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title: State ID/ Driver License		Document Title: Social Security Card
Issuing Authority		Issuing Authority: MN DMV		Issuing Authority: Social Security Administration
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				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		A&A Reliable Home Health Care , LLC

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
1821 University Ave W, Suite 295	Saint Paul	MN	55104

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing 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	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

A&A Reliable Home Health Care, LLC
1821 University Ave W, Suite S-295
Saint Paul, MN 55104

Phone: 651-470-9549
Fax: 651-493-2930
WWW.aareliable.com

Minnesota Home Care Bill of Rights

Statement of Rights

A Client who receives home care services in the community has these rights:

1. Receive written information, in plain language, about rights before receiving services, including what to do if rights are violated.

2. Receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services.

3. Be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services.

4. Be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan.

5. Refuse services or treatment.

6. Know, before receiving services or during the initial visit, any limits to the services available from a home care provider.

7. Be told before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs, or other sources if known; and what charges the client may be responsible for paying.

8. Know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services.

9. Choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, other health programs or public programs.

10. Have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information.

11. Access the client's own records and written information from those records in accordance with the Minnesota Health Records Act, Minnesota Statute Sections 144.291 to 144.298.

12. Be served by people who are properly trained and competent to perform their duties.

13. Be treated with courtesy and respect, and to have the client's property treated with respect.

14. Be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act.

15. Reasonable, advance notice of changes in services or charges.

16. Know the provider's reason for termination of services.

17. At least ten calendar days' advance notice of the termination of the service bu a home care provider. This clause does not apply in cases where:

- The client engages in conduct that significantly alters the terms of the service plan with the home care provider.

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- The client, person who lives with the client, or others create an abusive or unsafe work enviornment for the person providing home care services.

- An emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider.

18. A coordinated transfer when there will be a change in the provider of services.

19. Complain to staff and others of the client's choice about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property, and the right to recommend changes in policies and services, free from retaliation, including the threat of termination of services.

20. Know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint.

21. Know the name and address of the state or county agency to contact for additional information or assistance.

22. Assert these rights personally, or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation.

23. Place an electronic monitoring device in the client's or resident's space in compliance with state requirements.

Effective January 1,2020

IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING YOUR HOME CARE SERVICES, YOUMAY CALL, WRITE, OR VISIT THE OFFICE OF HEALTH FACILITY COMPLAINTS, MINNESOTA DEPARTMENT OFHEALTH. YOU MAY ALSO CONTACT THE OMBUDSMAN FOR LONG-TERM CARE.

Office of Health Facility Complaints (651) 201-4201 1-800-369-7994 Fax: (651) 281-9796 Mailing Address: Minnesota Department of Health Office of Health Facility Complaints 85 East Seventh Place, Suite 300 P.O. BOX 64970 St. Paul, MN 55164	Ombudsman for Long-Term Care (651) 431-2555 1-800-657-3591 Fax: (651) 431-7452 Mailing Address: Home Care Ombudsman Ombudsman for Long-Term Care PO BOX 64970 St. Paul, MN 55164	You may also contact: Phone:(651) 470-9549 Fax: (651)493-2930 A&A Reliable Home Health Care Mailing Address: 1821 University Ave w, STE 295 Saint Paul, MN 55104 Complaints may be directed to: Yeng Xiong

I acknowledge that I have been provided with a copy of the Home Care Bill of Rights. I have read the Bill of Rights or had it explained to me. I understand the Bill of Rights and have had a chance to have all of my questions answered.

Print Employee Name: _____

Employee Signature: _____ Date: _____