



NEW HIRE CHECK LIST
Demographic Information

Name:				
Gender: Male/Female/Other	Height:	Weight:	Eye Color:	Hair Color:
SSN:				
Company Name & EIN:				
Home Address:				
Home Number:				
Mobile Number:				
Drivers License Num <small>(state issued)</small>				
Email Address:				
Place of Birth:				
NPI Number: <small>(if applicable)</small>				
CAQH ID: <small>(if applicable)</small>				
CAQH Login & Password				

Degree/Training/Licensure/Certifications/Organization Affiliations
(Attach related copies of documentation)

Type	Number	Expires	Date Completed	Diploma - Degree/s Type/Date
CPR				
CPI				
CCFA/DFCS Cert.				
Essential/Relias Learning				
LAPC/LPC <small>(circle one)</small>				
LMSW/LCSW <small>(circle one)</small>				
MFT/LMFT <small>(circle one)</small>				
Addiction Cert.				
Psychologist/ Psychiatrist				
Other				



CONSENT FOR RELEASE OF INFORMATION

I hereby give my consent for a criminal history record check. I understand that this is a preliminary check for employment purposes and that all prior arrest information will be reported by the Georgia Crime Information Center (GCIC) to the Owner. I understand that information received from the criminal history record check may be used as a basis for removing me from consideration for employment or separation from employment. I understand that if I am offered employment with APEX Family Healthcare Services (AFHS), my fingerprints will be taken, and a more extensive background investigation will be completed. I understand that failure to disclose any prior arrest will be grounds for disqualification from further consideration or termination of employment with APEX Family Healthcare Services. I understand that this consent is voluntary; however, I acknowledge that refuse to give this consent will remove me from further consideration for the position for which I applied. I also acknowledge that providing false information or failure to disclose any information pertaining to my identity or criminal history may be a violation of O.C.G.A. 16-10-20.

Contractor Signature

Date

Human Resource Director Signature

Date



PLEASE NOTE: All answers must be complete and legible. Mandatory – A 10 year employment history or a complete employment history if you have not worked 10 years

1. TITLE OF POSITION for which you are applying: _____ 2. N/A _____

PERSONAL INFORMATION

3. Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____

4. Present Address – Number and Street _____ City _____ State _____ Zip _____ County _____

5. Resident Telephone Number: _____ Business Telephone Number: _____

6. Are you at least 18 years of age? Yes No

7. Are you legally eligible for employment in the United States? Yes No

8. Are you fluent in any language other than English? Yes No If yes, please specify: _____

9. **EDUCATION:** (Check last year completed) 8 9 10 11 12 13 14 15 16 17 18

Name and Location of High School: _____ Did you graduate? Yes No
 GED or CA Proficiency? Yes No

School	Name and Location of School	Credits/Units Completed	Did you Graduate?	List Degree or Diploma	Major Studies (Indicate Graduate Study if Applicable)
Other: Technical, Trade, Business, etc.					

10. LICENSES and CERTIFICATES

Description (State: Professional, Trade, etc.) _____ Certificate No. _____ Issued By _____ Expiration Date _____

11. EMPLOYMENT HISTORY:

Begin with your most recent experience and account for all time during the **last ten (10) years**. If additional space is required attach additional sheets. Attaching a separate resume is recommended.



Date (Month and Year)	Employer's Name and Address	Job Titles and Duties
From:		
To:		
Total Yrs. Mos.		
Reason for Leaving:	Did you supervise?	If Yes, Number of Employees:
Monthly Salary \$	Hours Per Week	Supervisor's Name and Phone No.:

Date (Month and Year)	Employer's Name and Address	Job Titles and Duties
From:		
To:		
Total Yrs. Mos.		
Reason for Leaving:	Did you supervise?	If Yes, Number of Employees:
Monthly Salary \$	Hours Per Week	Supervisor's Name and Phone No.:

Date (Month and Year)	Employer's Name and Address	Job Titles and Duties
From:		
To:		
Total Yrs. Mos.		
Reason for Leaving:	Did you supervise?	If Yes, Number of Employees:
Monthly Salary \$	Hours Per Week	Supervisor's Name and Phone No.:

Any "Yes" Answers to items 12-17 MUST be explained on the line provided after each question.

12. Have you ever been convicted or have been shown by credible evidence to have subjected a child or adult to serious injury as a result of intentional or grossly negligent or neglect misconduct as evidenced by a oral written statement to this effect obtained at the time of application? (Conviction is not an automatic bar to employment, each case is considered individually.) __Yes __No

If yes, please explain _____

13. Are you related to any APEX Family Healthcare Services Services employee? __Yes __No

14. Have you been **previously** employed by APEX Family Healthcare Services? __Yes __No

If yes, please give job title and dates: _____

15. May we contact your current or most recent employer? If "no", please state the reason. __Yes __No

16. Do you have a current CPR certificate? __Yes __No If yes, issued when _____ by whom _____

17. Do you currently have a First Aid certificate? __Yes __No If yes, issued when _____ by whom _____

18. Name, address, and phone of a contact person _____
Their relationship to you? _____ years known _____

I HERBY CERTIFY that all the statements made in this application are true, complete, and correct to the best of my knowledge and belief and realize that inclusion of false information or omission of material could result in **DISMISSAL** from employment **OR REMOVAL** of my application from further consideration. I also hereby certify that I **Never have been shown by credible evidence (e.g. a court or jury, a department investigation, or other reliable evidence) to have abused, neglected, sexually exploited, or deprived a child or adult or to have subjected ant person to serious injury as a result of intentional or grossly negligent misconduct as evidenced by an oral or written statement to this effect obtained at the time of application and participate in the orientation and training as required under DHR under**



rule 290-2-5-.08-3.(b)1 and 2, and I have not made any material false statements concerning qualifications requirements either to APEX Family Healthcare Services or the department. I am not suffering from a communicable disease or mental health disorder which would hinder my job performance. I hereby authorize all my employers and police/sheriff department (unless otherwise stated) to release any and all information in regards to my employment as requested.

Signature of Applicant:	Date:
-------------------------	-------

For APEX Family Healthcare Services ONLY

Accepted By: _____ Reasons: Experience Education
 Rejected Date of Employment: _____ Other: _____
 Criminal Records check completed

Explanation: _____
 Approved by Director (signature below) _____ Date _____



APEX FAMILY HEALTHCARE SERVICES

EMERGENCY CONTACT INFORMATION

Emergency Contact

Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Contact Number _____

Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Contact Number _____

Your Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____



Drug Free Workplace

Contract Certification

I understand the drug-free workplace policy.

I agree, as a condition of my contract, to abide by the terms of this program.

I agree to notify the CEO of any criminal drug statue conviction for a violation occurring in the workplace no later than five (5) days after such conviction.

Contractor's Signature

Date



CONFIDENTIALITY STATEMENT

I, _____, understand that in the performance of my duties, I am required to have access to and am involved in the processing of consumers data, medical information and proprietary company policies and information.

I understand that I am to maintain the confidentiality of this data at all times, both at work and off duty.

I understand that a breach of this confidentiality may result in disciplinary action up to and including my termination. I further understand that I could be subject to legal action.

1. That all information received and handled as part of my contract with apex Family Healthcare Services is confidential.
2. That such information is not to be discussed or divulged to anyone other than for the purpose of reviewing and processing this information.
3. Information obtained will not be made available verbally or in writing to anyone except and unless approved by the CEO.
4. The violation of any of the above is grounds for disciplinary action up to and including dismissal.

I hereby certify that I have been informed of the above policy and have participated in the orientation and training concerning the privacy and confidentiality.

Contractor Signature

Date

Human Resource Director Signature

Date



PRIVACY POLICY

IMPORTANT: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

APEX FAMILY HEALTHCARE SERVICES, LLC. is required by law to protect certain aspects of your health care information known as **Protected Health Information or PHI** and to provide you with this Notice of Privacy Practices that meet or exceed the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

This Notice describes our privacy practices, your legal rights, and lets you know, how Apex Family Healthcare Services, LLC is permitted to:

- Use and disclose PHI about you
- How you can access and copy that information
- How you may request amendment of that information
- How you may request restrictions on our use and disclosure of your PHI.

In most situations we may use this information described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

PLEASE READ THE FOLLOWING DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT THE: HIPAA Privacy Officer Liaison, 2 Peachtree Street NW, Room 29-210, Atlanta, Georgia 30303-3142 and someone will contact you.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice: This Notice describes your legal rights, advises you of our privacy practices, and lets you know how AFHS is permitted to use and disclose Protected Health Information (PHI) about you.

Uses and Disclosures of PHI: Apex Family Healthcare Services, LLC may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission.

Examples of our use of your PHI:

For treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.



For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Use and Disclosure of PHI Without Your Authorization. Apex Family Healthcare Services, LLC is permitted to use PHI without your written authorization, or opportunity to object in certain situations, including:

- For Apex Family Healthcare Services, LLC use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
- To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or for activities related to compliance with the law;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew;
- To a public health authority in certain situations (such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease as required by law);
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law;
- We may use or disclose health information about you in a way that does not personally identify you or reveal who you are. Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization, (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). **You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information based upon that authorization.**

Patient Rights: As a patient, you have a number of rights with respect to the protection of your PHI, including:



The right to access, copy or inspect your PHI. This means you may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.

We have forms available for you to request access to your PHI. We will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer liaison listed at the end of this Notice.

The right to amend your PHI. The right to request amending your PHI. You have the right to ask us to amend written medical information that we may have about you. If errors are found, we will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information, but only in certain circumstances. For example, if we believe the information is correct and no errors exist, your request will be denied. If you wish to request that we amend the medical information that we have about you, you should contact in writing the privacy officer listed at the end of this Notice.

The right to request an accounting of our use and disclosure of your PHI. You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, such as our billing company or a medical facility from/to which we have transported you.

We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact the privacy officer listed at the end of this Notice.

The right to request that we restrict the uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. However, if you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide you with emergency treatment. Apex Family Healthcare Services, LLC is not required to agree to any restrictions you request, but any restrictions agreed to by Apex Family Healthcare Services, LLC are binding on Apex Family Healthcare Services, LLC.

Right to Obtain Copy of Paper Notice on Request. You have a right to a copy of this notice. You may request a copy of this notice at any time. An electronic copy of this notice is available electronically at your request. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

Revisions to the Notice: Apex Family Healthcare Services, LLC reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting the Privacy Officer identified below.

Your Legal Rights and Complaints: You also have the right to complain to us, to the HIPAA Privacy Contact Person or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to the privacy officer listed at the end of this Notice. Individuals will not be retaliated against for filing a complaint.

Our HIPAA Privacy Contacts: Any questions or concerns relating to Apex Family Healthcare Services, LLC privacy policies and practices should be directed to the Privacy Contact Officer & Coordinator:

Contact:

Privacy Officer
2 Peachtree Street NW
Room 29-210

Privacy Coordinator
2 Peachtree Street NW
Room 22-240



Atlanta, Georgia 30303-3142

Atlanta, Georgia 30303-3142

By my signature below, I _____, client ____, employee ____ or sub-contractor ____ of APEX FAMILY HEALTHCARE SERVICES LLC, acknowledge that I have received a copy of the Privacy Policy and that these rights have been fully explained to me.

Signature

Date



EMPLOYMENT REFERENCES (you must list at least 2 verifiable references)

NAME: _____

ADDRESS: _____

PHONE: _____

EMPLOYER _____

NAME: _____

ADDRESS: _____

PHONE: _____

EMPLOYER _____

NAME: _____

ADDRESS: _____

PHONE: _____

EMPLOYER _____

PERSONAL REFERENCE

NAME: _____

ADDRESS: _____

PHONE: _____

YEARS KNOWN _____

YOUR NAME _____

ADDRESS _____

PHONE _____



Ethical Code of Conduct Statement

Definitions: “Contracted Staff” is any person who currently represents Apex Family Health Care Services and who’s legal filing status for services provided on behalf of Apex Family Healthcare Services on IRS form 1099.

Contracted staff will maintain competence in their area of assignment. Contracted staff will base their practice on current standards of care, recognizing boundaries and limitations of competence of experience. Contracted staff provides only those services for which they are qualified by education, training and experience. Contracted staff does not perform any assignment, or profess to be knowledgeable in areas beyond their educational/certification/licensure expertise.

Contracted staff is fair and honest in dealing with all consumers, whether those persons are fellow clinicians, supervisors, clients, ancillary service providers, and/or client family members. They do not make statements that are misleading or deceptive. They strive to maintain objectivity and to be aware of personal beliefs, values, and needs that may limit effectiveness with persons served.

Contracted staff respects the fundamental dignity and worth of all persons. They strive to protect and promote the personal rights of all persons served. Contracted staff will be respectful of cultural, individual, and role differences. Contracted staff will not knowingly participate in discriminatory practices. They will respect each individual’s right to privacy, confidentiality and right of self-determination of persons served.

Contracted staff seeks to contribute to the welfare of others. Contracted staff seeks to resolve conflict and perform their role in a responsible manner which strives to avoid harm to all fellow consumers; as well as, the clientele served. Contracted staff is sensitive to the differences in power between themselves, subordinates, and persons served and do not exploit or mislead them. They avoid relationships that jeopardize the best interests of persons served.

Contracted staff members are aware of boundaries and relationships developed with persons served. Contracted staff does not exploit relationships for financial or personal gain. Contracted staff does not engage in dual relationships with clientele and work openly with supervisor/clinical supervisor to address boundary/transference/counter transference issues as they do at times arise.

Contracted staff members conduct themselves in a professional manner, appropriate to their work roles, respectful of persons served and co-workers. AFHS recognizes that private conduct is a personal matter, except where it compromises fulfilling of agency responsibilities. Contracted staff members will comply with agency standards and the law.



Contracted staff members are concerned about and strive to mitigate causes of human suffering. They promote development of resources, services and policies which enhance the sober welfare of the persons served and the community at large.

Questions about the ethical code of conduct, reporting of concerns or complaints of violations will be directed to the Executive Management Team; CEO, COO or the Clinical Director without fear of reprisal.

I agree that I have read and understand the entire set of Ethical guidelines explained above. I acknowledge my obligation and Contracted staff agreement to uphold the Code of Conduct, the duties and responsibilities set forth and will continue to abide by Apex Family Healthcare Services Code of Conduct. I understand that violations of the Code of Conduct may lead to termination of the Contracted staff agreement.

SIGNATURE

DATE

PRINT NAME



Interview Completed: What Are My Next Steps

- 2nd Review of Completed Application
- Tentative Verbal Offer of Employment including salary
- Written tentative Offer of Employment
- Signed tentative offer of Employment with valid ID & SS Card
- Scheduling of Drug Screen and Background Check (cost associated)
- Relias Training Courses Assigned if needed (1/2 must be completed before caseload assignment)
- Request for additional documents due within 48 hours (see list of documents to be emailed to HR@apexfamilyhealthcare.com)
- All request for documents received
- Orientation Scheduled (Every Tuesday)
- Documentation Training Scheduled (1st, 2nd, 4th Wednesday)
- Client Services Training (Every Thursday)
- Introduction to Clinical Director (Every Thursday)
- Case Load Assignment / Getting Started w/ Caseload Training (Every Thursday & Friday)
- Authorization / GAMMIS /Discharge Training (Every Monday)



APEX STAFF REQUIRED DOCUMENTS

- Valid State Identification (Driver's License)
- Social Security Card (SSN)
- Application Package (Completed)
- Verifiable References-No less than 3 can be in letter form on business letterhead
- Emergency Contact

Completion of the following Pre-Employment screenings:

- Criminal Record Check (Live Scan) State and Federal (\$\$)**agency must schedule**
- Drug Screen (\$\$)**agency must schedule**
- Physician statement of present health condition for employment/TB screen (\$\$)

Completion of the following trainings:

- CPR (\$\$)**agency can assist with scheduling**
- CPI (\$\$)**agency must schedule**
- Essential Learning (40)**agency must schedule**

Copies of the following documents:

- Resume with 5 year work History
- Copy of Education Verification (Diplomas)
- **Official** Tech/College/Graduate School Transcripts (unless licensed) – *official copy of transcripts required before caseload but unofficial will assist through on-boarding*
- Current Professional License** **official card needed**
- National Provider Identification Number (NPI)
- Employee Identification Number (EIN)**agency will send**
- I-9 Form **agency will send to you**
- Contractor 1099 statement**agency will send to you**
- Professional Liability Insurance (Clinicians and Contractors) \$1Million - \$3Million
- Automobile Insurance Declaration Page (100,000/300,000/100,000/ with Medical)
- Independent Contractor Agreement**agency will send to yu**