agency for persons with disabilities
State of Florida

ATTESTATION OF GOOD MORAL CHARACTER

Updated July 29, 2024

Employee/Contractor Name:
Health Care Provider/Employer Name:
Address of Health Care Provider:

By signing this form, I affirm and attest that I meet the Moral Character requirements for employment as required pursuant to Chapter 435, Florida Statutes, and Section 393.0655, Florida Statutes.

I have not been arrested with disposition pending or found guilty of regardless of adjudication or entered a plea of nolo contendre (no contest) to or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction for any of the offenses listed below.

Criminal offenses found in section 435.04, F.S.

(a) Section 39.205, relating to the failure to report child abuse, abandonment, or neglect.

(b) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(c) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(d) Section 414.39, relating to fraud, if the offense was a felony.

(e) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 782.04, relating to murder.

(h) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(i) Section 782.071, relating to vehicular homicide.

(j) Section 782.09, relating to killing of an unborn child by injury to the mother.

(k) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(l) Section 784.011, relating to assault, if the victim of the offense was a minor.

(m) Section 784.021, relating to aggravated assault.

(n) Section 784.03, relating to battery, if the victim of the offense was a minor.

(o) Section 784.045, relating to aggravated battery.

(p) Section 784.075, relating to battery on staff of a detention or commitment facility or on a juvenile probation officer.

(q) Section 787.01, relating to kidnapping.

(r) Section 787.02, relating to false imprisonment.

(s) Section 787.025, relating to luring or enticing a child.

(t) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody

proceedings.

(u) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(v) Section 787.06, relating to human trafficking.

(w) Section 787.07, relating to human smuggling.

(x) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(y) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(z) Section 794.011, relating to sexual battery.

(aa) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(bb) Section 794.05, relating to unlawful sexual activity with certain minors.

(cc) Section 794.08, relating to female genital mutilation.

(dd) Chapter 796, relating to prostitution.

(ee) Section 798.02, relating to lewd and lascivious behavior.

(ff) Chapter 800, relating to lewdness and indecent exposure.

(gg) Section 806.01, relating to arson.

(hh) Section 810.02, relating to burglary.

(ii) Section 810.14, relating to voyeurism, if the offense is a felony.

(jj) Section 810.145, relating to video voyeurism, if the offense is a felony.

(kk) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(ll) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(mm) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(nn) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(oo) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(pp) Section 826.04, relating to incest.

(qq) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

(rr) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(ss) Former s. 827.05, relating to negligent treatment of children.

(tt) Section 827.071, relating to sexual performance by a child.

(uu) Section 831.311, relating to the unlawful sale, manufacture, alteration, delivery, uttering, or possession of counterfeit-resistant prescription blanks for controlled substances.

(vv) Section 836.10, relating to written or electronic threats to kill, do bodily injury, or conduct a mass shooting or an act of terrorism.

(ww) Section 843.01, relating to resisting arrest with violence.

(xx) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(yy) Section 843.12, relating to aiding in an escape.

(zz) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(aaa) Chapter 847, relating to obscene literature.

(bbb) Section 859.01, relating to poisoning food or water.

(ccc) Section 873.01, relating to the prohibition on the purchase or sale of human organs and tissue.

(ddd) Section 874.05, relating to encouraging or recruiting another to join a criminal gang.

(eee) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(fff) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(ggg) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(hhh) Section 944.40, relating to escape.

(iii) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(jjj) Section 944.47, relating to introduction of contraband into a correctional facility.

(kkk) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(lll) Section 985.711, relating to contraband introduced into detention facilities.

435.04(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Section 393.0674(2), felony offenses for the release or use of information from juvenile records of the Agency for Persons with Disabilities for any purpose other than screening for employment.

Criminal Offenses listed in section 393.0655 (5), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(f) Section 817.234, relating to false and fraudulent insurance claims.

(g) Section 817.505, relating to patient brokering.

(h) Section 817.568, relating to criminal use of personal identification information.

(i) Section 817.60, relating to obtaining a credit card through fraudulent means.

(j) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(k) Section 831.01, relating to forgery.

(l) Section 831.02, relating to uttering forged instruments.

(m) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(n) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

The following acknowledgements apply to all Direct Service Providers and/or Employees, Contract Providers, and Volunteers. Please initial each statement.

_____ I affirm that I have not been designated as a sexual predator pursuant to s. 775.21; a career offender pursuant to s. 775.261; or a sexual offender pursuant to s. 943.0435, unless the requirement to register as a sexual offender has been removed pursuant to s. 943.04354.

_____ I understand that I must acknowledge the existence of any applicable criminal record relating to the above lists of offenses including those under any similar statute of another jurisdiction, regardless of whether or not those records have been sealed or expunged.

_____ I understand that, while employed or volunteering in any position that requires an APD background screening as a condition of employment, I must immediately notify my supervisor/employer of any arrest, any notice of possible criminal prosecution including any violation or infraction mandating a court appearance. Reporting must be done immediately if during normal working hours or immediately the next business day if after normal working hours.

ONE OF THE FOLLOWING STATEMENTS MUST BE SIGNED:

I attest that I have read the above carefully and state that my attestation here is true and correct and that my record **does not contain any of the above listed offenses.** I understand, under penalty of perjury, all employees in such positions of trust or responsibility shall attest to meeting the requirements to the background screening standards set forth in Chapter 435 and Section 393.0655.

_____

Signature of Affiant *Date*

----------OR----------

My record **contains one or more of the applicable disqualifying** acts or offenses listed above.

_____

Signature of Affiant *Date*

Note: If you have previously been granted an APD exemption for this disqualifying offense, a copy of the APD exemption letter must be attached.

----------OR----------

(proceed to next page)

I am a licensed physician, licensed nurse, or other professional licensed and regulated by the Department of Health. I will be **holding a position that is within the scope of my licensed practice**, and I am not subject to the screening provisions of section 393.0655, Florida Statutes.

Signature of Affiant *Date*

(Position for Provider/Employer listed on pg. 1)

KM HOME CARE LLC
INDEPENDENT CONTRACTOR AGREEMENT

Form O1

This Independent Contractor Agreement ("Agreement") is made and is effective this _____ of _____, 20____, by and between _____, ("Contractor") and KM HOME CARE LLC, the ("Agency"). Now, therefore, Contractor and Agency agree as follows:

1. **Engagement and Services**. Agency hereby offers to Contractor, and Contractor accepts engagement to provide services to Waiver Recipients as relayed to Contractor upon request by the Waiver Support Coordinator (WSC) and in accordance with the approved Service Authorization from the Agency for Persons with Disabilities (APD), in compliance with, and according to, all professional standards of practice, laws and rules. Such services will be provided by Contractor after Agency offers a specific job for a specific Agency client and which Contractor accepts the job. Specific recipient jobs are offered to Contractors according to availability of Contractors on a first-come, first-offered basis, as well as client satisfaction feedback and other factors. Contractor is free to accept or refuse any job offer from the Agency.

2. **Place of Provision of Services**. Contractor agrees to render services primarily at the residences of Agency's clients.

3. **Schedule of Provision of Services**. Contractor agrees to provide services to Waiver Recipients, as assigned by the Waiver Support Coordinator (WSC) and in accordance with the approved Service Authorization from the Agency for Persons with Disabilities (APD), in a safe and effective manner according to the schedule developed based on the patient's needs as determined by the Waiver Support Coordinator (WSC) and as relayed to the Contractor by the Agency.

4. **Licenses or Certification**. If the Contractor is providing services to Waiver Recipients which require a license or certification, the contractor is responsible for ensuring that his or her own license or certification remains current and valid during the period of contract. Failure to maintain valid license or certification status will cause suspension of job offers and may be the basis for termination of this Agreement with the Agency. Contractor understands and acknowledges that he or she is responsible for fulfilling all continuing education requirements and all other requirements to maintain such license or certification. Contractor shall inform the Agency if his or her license or certification is invalidated at any time and for any length of time. This section does not apply to non-licensed or certified positions.

5. **Communicable Disease**. It is the responsibility of the Contractor to ensure that Waiver Recipients are not placed at risk by immediately removing him or herself from contact with the Waiver Recipients if he or she is found to have or is suspected of having a communicable disease that could be casually transmitted. In the event that a Contractor refuses to remove him or herself, the Agency will remove the Contractor from direct patient care and report the situation to the county health department as an immediate threat to health, welfare and safety, as appropriate.

6. **Background Screening**. The Contractor agrees that as a condition of this Agreement that he/she must clear a Level 2 criminal background screening by the Agency through the appropriate agency of State of Florida. Contractor agrees to bear the cost associated with any background screening.

7. **Criminal Arrests**. The Contractor agrees to inform the Agency, as soon as practicable, of contractor's arrest by any law enforcement agency and prior to providing care to any to Waiver Recipient after such arrest.

8. **Transportation**. Contractor agrees to provide and maintain his or her own transportation needs for travel to and from Waiver Recipient jobs. Contractor agrees to provide notice and disposition to the Agency of all traffic citations issued by any law enforcement officer to Contractor.

9. **Insurance**. Contractor shall maintain all required insurances, including automobile insurance in the minimum amount required by state law. Contractor agrees to provide Agency with copies of all required insurance policies prior to or upon execution of this agreement, and annually thereafter or upon renewal or substitution.

10. **Confidentiality**. Contractor shall maintain and preserve the confidentiality of all patient health-related information in accordance with all State and Federal privacy laws and Agency policy. Agency expressly prohibits you from discussing your fees with another contractor. Doing so may result in termination of your contract with Agency.

11. **Patient Visit Notes and Time Sheets**. Contractor shall be responsible for creating, updating, maintaining and submitting to the Agency the clinical record and service notes for each Waiver Recipient for whom he or she provides care or service. Contractor shall maintain a time sheet for each Waiver Recipient for which Contractor provides service each week. Contractor shall submit clinical records, service notes and Contractor time sheets for each Waiver Recipient for whom Contractor provides care or service, to the office of the Agency according to the most current revision or edition of the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook.

12. **Term, Renewal and Termination**.
   A. This Agreement shall begin at the time both parties' signatures are affixed hereto and shall terminate one year thereafter, if not sooner by other terms herein, and may be renewed thereafter, from year to year, upon terms agreed to by the parties at that time.
   B. This Agreement may be terminated by either party at any time upon written notice.
   C. Any limitations set forth in this Agreement, including but not limited to the "Non-Compete" portion of this agreement, shall remain in force and effect until the expiration of that limitation, by its terms.

13. **Tools and Supplies**. Unless otherwise agreed to by the Agency in advance, Contractor shall be solely responsible for procuring, paying for and maintaining any supplies and equipment necessary or appropriate for the performance of Contractor's services hereunder.

14. **Controlling Law and Venue**. This Agreement shall be governed by and construed in accordance with the laws of the State of Florida. Any action to enforce or construe any element of this Agreement shall be conducted in Miami-Dade County, Florida.

15. **Headings**. The headings in this Agreement are inserted for convenience only and shall not be used to define, limit or describe the scope of this Agreement or any of the obligations herein.

16. Severability. If any term of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, then this Agreement, including all of the remaining terms, will remain in full force and effect as if such invalid or unenforceable term had never been included.

17. Maintenance of Documents. The Agency shall maintain possession of the originally signed copy of this document, with access for copying provided to the Contractor at reasonable times. The Contractor shall obtain a copy of this Agreement upon the signing hereof by both parties. No provision in this or any other agreement is enforceable unless it is signed by both parties.

18. Payment for Services. Payment for services provided by Contractor under this agreement is calculated from Saturday through Friday, (the Care Week), and will be issued by direct deposit every two (2) weeks on Saturday. Contractor shall bear all of Contractor's expenses incurred in the performance of this Agreement.

19. Legal Costs and Relief. If any legal action is brought for the enforcement of this Agreement, or because of a dispute, breach or default in connection with any provision of this Agreement, the Agency shall be entitled to recover reasonable attorney's fees, court costs and all reasonable expenses, even if not taxable as court costs (incurred at all levels of the judicial process) in addition to any other relief, including injunctive relief, to which the Agency may be entitled, whether incurred prior to litigation, at trial or upon appeal. Attorneys' fees shall include, without limitation, paralegal fees, investigative fees, administrative costs, postage, sales and use taxes and all other charges billed by the attorney to the Agency.

20. Independent Contractor Relationship. Contractor is, and for all aspects concerning this Agreement shall be, an Independent Contractor and not an employee, partner or agent of Agency. Contractor shall not be entitled to nor receive any benefit normally provided to Agency's employees such as, but not limited to, workers' compensation insurance, vacation payment, retirement, health care or sick pay. Agency shall not be responsible for withholding income or other taxes from the payments made to Contractor. Contractor shall be solely responsible for filing all returns and paying any income, social security or other tax levied upon or determined with respect to the payments made to Contractor by the Agency pursuant to this Agreement.

It is intended by the parties that the Contractor will provide periodic services to Agency clients, at Contractor's option, and that Contractor will obtain and maintain income producing activities other than the Agency and that Contractor is not dependent, and will not depend, solely upon the Agency for Contractor's total income. The Agency encourages Contractor to seek and maintain other sources of income and not rely solely upon the Agency for Contractor's financial sustenance.

Further, Contractor stipulates that the Agency will not supervise, train or instruct Contractor regarding the means, methods or manner in which Contractor provides services to any specific Agency client. However, Contractor acknowledges that the Agency shall determine the competency of Contractor to provide the services of the nature which the Agency offers prior to the Agency offering a job to Contractor.

21. Orientation

Contractor agrees to attend an orientation session prior to signing this Agreement which at which the terms of this Agreement and other requirements of the relationship with the Agency will be discussed.

22. Final Agreement & Notice.
This Agreement, including the Independent Contractor Guidelines, constitutes the final understanding and Agreement between the parties with respect to the subject matter hereof and supersedes all prior negotiations, understandings and agreements between the parties, whether written or oral. This Agreement may be amended, supplemented or changed only by an agreement, either on this document with both parties' initials, or separately in writing signed by both of the parties. Any notice given under this Agreement shall be sufficient if it is in writing and if sent by certified or registered mail to the address hereon.

IN WITNESS WHEREOF, this Agreement has been executed by the parties as of the date latest date below.

Contractor:

By: _____

Print Name: _____

Date: _____

For the Agency:

By: _____

Print Name: _____

Date: _____

Payment Terms

$_____ per hour;

$_____ per _____

Contractors Initials:_____ ; Date _____

Agency Initials:_____ ; Date _____

RENEWAL

IN WITNESS WHEREOF, this Agreement has been renewed by the parties as of the date latest date below.

Contractor:

By: _____

Print Name: _____

Date: _____

The Agency:

By: _____

_____, Owner
(Print Name)

Date: _____

Payment Terms

$_____ per hour;

$_____ per _____

Contractors Initials:_____ ; Date _____

Agency Initials:_____ ; Date _____

KMHC Home Care

Independent Contractor Agreement and Workers' Compensation Waiver

This agreement is made between KM Home Care LLC
_____, and is effective as of _____.

1. Independent Contractor Status

The Contractor acknowledges and agrees that they are an independent contractor and not an employee of KM Home Care LLC for any purpose, including workers' compensation insurance. The Contractor further acknowledges that they have no employees, casual laborers, or sub-contractors performing work on behalf of KM Home Care LLC. The Contractor is solely responsible for their own operations, including the methods and means by which the work is performed.

2. Waiver of Workers' Compensation Coverage

The Contractor understands and agrees that they are not covered by the workers' compensation insurance policy of KM Home Care LLC. As an independent contractor, the Contractor waives any and all rights to file any workers' compensation claims or other claims against KM Home Care LLC in the event of an accident or injury occurring while performing work for any mutual client during the term of their engagement with KM Home Care LLC.

3. Contractor's Certification

The Contractor certifies that they are fully compliant with all legal, regulatory, and contractual requirements necessary to be considered an independent contractor. The Contractor further certifies that they will maintain their own business operations, including obtaining and maintaining appropriate insurance, paying applicable taxes, and ensuring that all work is performed in accordance with industry standards and applicable laws.

4. Control Over Work

The Contractor affirms that they have control over how, when, and where the work is performed. KM Home Care LLC will not dictate the methods, manner, or means of the work, and the Contractor's work will be completed at their discretion based on their knowledge, expertise, and training.

5. Tools and Equipment

The Contractor agrees that they are responsible for providing their own tools and equipment necessary for the performance of the work. KM Home Care LLC will not provide tools, materials, or other resources required to perform the work.

KM Home Care llc. Phone: 786-310-5591 **Fax:** 786-310-5592
Email:kmhomecareapd@gmail.com

6. Scheduling

The Contractor will have the autonomy to set their own hours and schedule. While the Contractor agrees to inform KM Home Care LLC of their schedule, they retain the right to cancel or modify their schedule at their own discretion.

7. Workers' Compensation Insurance

The Contractor acknowledges that they are responsible for obtaining and maintaining their own workers' compensation insurance coverage, if applicable, and that KM Home Care LLC does not provide such coverage for independent contractors.

8. Indemnification

The Contractor agrees to indemnify and hold KM Home Care LLC harmless from any claims, losses, or damages arising from the Contractor's failure to maintain appropriate insurance or comply with any applicable laws or regulations regarding workers' compensation.

IN WITNESS WHEREOF, the parties hereto have executed this agreement as of the date first above written.

Contractor:
Name: _____

Signature: _____

Date: _____

KM Home Care LLC:
Authorized Representative: Ana V Exposito DON/CEO

Signature: _____

Date: _____

KM Home Care llc. Phone: 786-310-5591 **Fax:** 786-310-5592
Email:kmhomecareapd@gmail.com

Staff Name: _____ Position: _____

KM Home Care LLC

ITEM	DESCRIPTION	INITIALS
NON DISCRIMINATION POLICY	As a recipient of Federal financial assistance, our Nurse Registry does not exclude, deny benefits to or otherwise discriminate against any person on the grounds of race, color, national origin, disability or age in admission to,participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by our Nurse Registry directly or through a contractor or any other entity with which our Nurse Registry arranges to carry out its programs and activities. This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, and 91. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.) In case of question please contact the Nurse Registry Section 504 Coordinator.	
ANTI-HARASSMENT POLICY	Our Nurse Registry strives to maintain a work environment that is free of discrimination, intimidation, hostility, or other offenses that might interfere with work performance. In keeping with this desire, we will not tolerate any unlawful harassment of staff by anyone, including any supervisor, co-worker, vendor, client, or customer. What Is Harassment? Harassment consists of unwelcome conduct, whether verbal, physical, or visual, that is based upon a person's protected status, such as color, disability, gender, national origin, race, religion, age or other legally protected status. We will not tolerate harassing conduct that affects tangible job benefits, that interferes unreasonably with an individual's work performance, or that creates an intimidating, hostile, or offensive working environment. Harassment can take many forms, including, but not limited to: words, signs, jokes, pranks, intimidation, physical contact, or violence.	
UNIVERSAL PRECAUTIONS	It is the policy of our Nurse Registry that health care providers will adhere to the following, when delivering care to all patients. By adhering to the following universal precautionary measures, the risk of transmission of disease, is decreased when the infection status of the patient is unknown. **Gloves** must be worn when delivering patient care, handling specimens, doing domestic cleaning, and handling items that may be soiled with blood or body fluids. Gloves or aprons must be worn during procedures or while managing a patient situation when there will be exposure to body fluids, blood, draining wounds or mucous membranes. Gloves are to be worn when handling all specimens to prevent contamination from body specimen fluids or blood. **Mask and protective eyewear** or face shield must be worn during procedures that are likely to generate droplets of body fluids, blood or when the patient is coughing excessively. **Hand washing**: Hands must be washed before gloving and after gloves are removed. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with body fluids or blood and after all patient care activities. Health care providers, who have open cuts, sores, or dermatitis on their hands must wear gloves for all patient contact.	
CONSENT FORM TO RELEASE PHYSICAL-MEDICAL EXAMINATION CRIMINAL BACKGROUND SCREENING DATA FORM	I have been formally instructed that my Physical Examination Form, and any medical and/or Criminal Background screening data is maintaining confidentially and understand that the medical information regarding my health status may not be discussed with anyone, either inside or outside the Nurse Registry (except an needed to conduct the business of the day). I understand that no medical/criminal data are to be removed from the Nurse Registry unless a **"Release of Information"** form has been completed and signed for me. It is my understanding that such Release of Information (THIS FORM), authorize the Nurse Registry to release my Physical/Background Information data to State/Federal surveyors at their request if needed for conduct the annual survey or any necessary investigation. I have been formally instructed in the Personnel Policies and Regulations, and I have read and signed a job description for my specific classification.	

Staff/Contractor Signature: _____ Date: _____

Staff Name: _____ Position: _____

KM Home Care LLC

ITEM	DESCRIPTION	INITIALS
INFECTION CONTROL	For your well being, and the well being of your patient, we outline the following procedures to guard against infection. 1. Please wash your hands before and after each procedure. 2. In the event of an exposure to a pathogen please make an immediate report to the Registered Nurse in charge. This office must be notified immediately and the staff involved must report to the nearest hospital emergency room and will return to work only after a physician has cleared him/her of any communicable infection. 3. When working with an AIDS and other high risk infection's patient, remember to avoid any and all contact with the patient's body fluids, especially blood and blood products. Read and be familiar with the attached pamphlet on how to prevent catching the AIDS or any other virus. 4. This Nurse Registry is not liable for our health care worker who contracts AIDS virus in the course of performing his/her professional duties. For more policies on infection control our Nurse Registry asks all of its staff to read the accompanying scripts which are summaries from the CDC and the Department of Health and Rehabilitative Services. I hereby acknowledge that I have read and understand the Infection Control Policy contained in the Field staff Procedure Manual. I am familiar with the procedures appropriate to my position as a field Staff.	
USE OF PERSONAL PROTECTIVE EQUIPMENT	I, the undersigned, understand and agree that as a condition of employment I am required to wear/use the following personal protective equipment supplied and/or required by my employer: Company Supplied: _____ _____ Company Required (Supplied by Staff/Contractor): _____ _____ I agree to inform my employer immediately upon the failure of any of the above listed equipment so the same can be promptly repaired or replaced. In the event I sustain an on-the-job injury as a direct result of my failure to wear/use the personal protective equipment listed above, my workers' compensation benefits could be substantially reduced.	
WAIVER OF RIGHTS	I, the undersigned, understand that the hazards of my job; have been fully explained to me by my supervisor: _____ I further acknowledge that my employer has supplied me and/or I have supplied the following Personal Protective Equipment: _____ _____ _____ _____ I understand that it is necessary for me to use this Personal Protective Equipment to fully protect myself from the hazards of my job. I realize that in the event I do not use all of this Personal Protective Equipment and I sustain a personal injury caused by my failure to use/wear said Personal Protective Equipment, I may be denied up to 25% of the indemnity portion of my claim. As provided by this State's Workers' Compensation statutes.	
PERSONNEL POLICIES SAFE AND ADEQUATE CARE OF THE PATIENT (SAFETY OF THE PATIENT'S IMMEDIATE ENVIRONMENT)	This Nurse Registry, hereby sets forth the following guidelines to be adhered to by all staff of this Nurse Registry: * Upon arrival at a patient's home, the nurse/Staff shall make physical checks of the essential safety devices such as proper locks on doors, proper ventilation, proper beds/chairs, proper bedding, adequate bathroom systems, adequate kitchen with all electrical devices, to be sure they are in good working condition. * The Staff shall also check the appropriate boxes on our "Patient Safety Checklist" and make the appropriate report to our offices as soon as possible * Upon receipt of such report, the Registered Nurse in charge shall take necessary action to ensure that any safety deficiencies are corrected. I have received, read, (or it has been read to me) and understand the "Company Policy and Safety Rules and Regulations", and agree to abide by them. I further understand that failure to do so could result in disciplinary action or termination.	

Staff/Contractor Signature: _____ Date: _____

Staff Name: _____ Position:_____

KM Home Care LLC

ITEM	DESCRIPTION	INITIALS
Staff STATEMENT OF COMMITMENT	I have read and understand The Nurse Registry, Personnel Policy Manual. In compliance with those policies I agree to conform to the following: -I will always maintain professionalism in the home to which I am assigned. -I will immediately contact The Nurse Registry, regarding any areas of discrepancy between the client's assessment of the assignment requirements and my understanding of my specific performance level as designated by The Nurse Registry -I have read and understand the Nurse Registry, job description appropriate to my level of performance. I will not accept assignments beyond my designated level as determined by The Nurse Registry performance -I will abide with the Nurse Registry Standard Code of Dress as described in the Personnel Policy Manual. -I will arrive in time for the assignments I have accepted. In the event of an emergency which may cause me to be late, I will notify the Nurse Registry, office of the situation and expected arrival time. -I will not accept any money or gifts from The Nurse Registry Clients. I will receive payment for services rendered directly from The Nurse Registry -I will notify The Nurse Registry, immediately if I am unable to arrive for my assignment within my due time or if I am unable to meet my assignment commitment. I understand the Nurse Registry, office will then contact the client. I also understand that not calling The Nurse Registry, office when I am unable to meet my assignment commitment will be grounds for immediate termination. -I will not make or accept personal telephone calls on the client's home. -I will not transport a patient or family member in my personal vehicle. -I will not smoke in a patient's home.	
VOLUNTARY SUBSTANCE TESTING	In order to protect myself and my employer, I _____ voluntarily authorize blood and urine testing for alcohol and/or drug use. I agree to allow such samples and testing to be completed at a time and place to be chosen by my employer. I understand should such samples and testing be requested it is either due to the company's Drug Free Workplace Program, suspicion that I am under the influence of alcohol/drugs which could result in an on-the-job injury, or may affect the quality of my work. I further authorize the results of samples/testing to be released to my employer.	
POLICY ON PATIENT'S PROGRESS NOTES	It is the policy of The Nurse Registry that weekly Progress Notes shall be written on each of our patients, preferably each Friday. Such a Progress Note, to be written on our standard "Progress Notes" form, shall be written by a Skilled Nurse/Professional/field staff, who also should supervise the case in review, together with Supervisor RN/Staff if applicable. Completed progress notes, along with other pertinent patient records, shall be submitted to the Registered Nurse in charge (at the office) once every week (Tuesday before 5:00 pm). During that period a note faxed from Staff may be use in place of the original, until the regular 1 week delivery time frame, progress note is received in the office. Health care staff members will ensure complete concise documentation of services, issues and conditions occurring during the period of services rendered to the client. It is our Policy that we allow the use of automatic mechanism to help our staff to complete their Progress Notes report like typing by Typewriter, Word Processor, or Computer Software, in compliance with the following steps: 1- Ensure the compliance of HIPAA regulations and guidelines, including the care of the Patient's Privacy Rights 2- Don't allow any other person access to any Patient Information needed to complete the work, if necessary finish the Notes at the staff's residence. 3- Destroy all Patient Information after completing the Progress Notes 4- Inform immediately to the Nurse Registry Privacy Officer if any breach of HIPAA guidelines for Patient's Privacy Rights is suspected. 5- In the use of Computer Software or any electronic device to help complete the progress note, the staff can not save any Patient Information in the Staff Personal Computer/tablet, is the patient's information is used, the Staff must delete that information, immediately after completing their work.	

Staff/Contractor Signature: _____ Date:_____

Staff Name: _____ Position:_____

KM Home Care LLC

ITEM	DESCRIPTION	INITIALS
Staff ACKNOWLEDGMENT OF PROBATION	I UNDERSTAND THAT I AM ON PROBATION AS A Staff FOR THE FIRST NINETY DAYS OF MY EMPLOYMENT WHICH STARTED ON _____ FOR THE PURPOSE OF THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW". I UNDERSTAND IF MY EMPLOYER DISCHARGES ME FOR UNSATISFACTORY WORK PERFORMANCE UNDER THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW" HE WILL NOT HAVE HIS ACCOUNT CHARGED FOR ANY UNEMPLOYMENT BENEFITS I MIGHT BE DETERMINED FOR IN THE FUTURE. I ACKNOWLEDGE THAT I SIGNED THIS FORM WITHIN SEVEN (7) DAYS OF MY EMPLOYMENT.	
NOTICE TO APPLICANTS	We comply with the Americans with Disabilities Act of 1990. During the interview process, you may be asked questions concerning your ability, to perform job-related functions. If you are given a conditional offer of employment, you may be required to complete a post-job offer medical history questionnaire and/or undergo a medical examination. If required, all entering staff in the same job category will be subjected to the same medical questionnaire and/or examination and all information will be kept confidential and in separate files. We are an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, sex, religion, national origin, handicap, or martial status. We assure you that your opportunity for employment with us depends solely upon your qualifications. **PLEASE READ AND SIGN STATEMENTS BELOW** I understand that in accordance with Florida Statute 443.131 (3) (a) (2), if hired, I will be placed on a 90 day probationary period. I further understand that if I am terminated for unsatisfactory work performance within the 90 day probationary period, my employer may seek to contest any unemployment benefit I might attempt to obtain as a result of my termination. I understand and agree that all policies, procedures, and the Staff Handbook may be modified, amended, or deleted by my employer with or without notice to me of such amendment, modification or deletion; that the policies and procedures are not intended to be a contract of employment nor do they give me a right of continued employment, and that my employment may be terminated at my option or that the option of my employer with agreements, or understandings regarding the terms of employment. There may be no amendments or exceptions to this statement unless they are in writing and signed by the president. I understand that I may be required to undergo blood and/or urinalysis screening for drug or alcohol use as part of the pre-employment process. In addition, all staff are subject to blood and/ or urinalysis screening for drug or alcohol use. I certify that all information given on this employment application, any resume that I submit to the company, and any related papers and answers given during oral interviews are true and correct. I understand that my employer will make a thorough investigation of my work and personal history. I authorize the giving and receiving of any such information requested by my employer during the course of such investigation. I understand that falsification of any information given by others during the course of this investigation of any derogatory information discovered as a result of this investigation may-subject-me-to-immediate-dismissal. I hereby release from liability all persons who provide information to my employer during the course of any such investigation.	
TRANSPORTATION RESPONSIBILITY CONTRACT	It has been explained to me that I am being offered employment by This Nurse Registry with the understanding that I have personal transportation at my disposal to be used for travel to and from the patient assignments. I further understand that I am responsible for auto liability of $ 10,000.00 / $ 20,000.00 for bodily injury and $ 5,000.00 in property damage. I also agree not to use my vehicle to transport any patient.	

Staff/Contractor Signature: _____ Date:_____

Staff Name:_____ Position:_____

ITEM	KM Home Care LLC DESCRIPTION	INITIALS
CONFIDENTIALITY STATEMENT	I HAVE BEEN FORMALLY INSTRUCTED IN MAINTAINING THE CONFIDENTIALITY OF THE MEDICAL RECORDS AND UNDERSTAND THAT THE MEDICAL INFORMATION REGARDING THE PATIENT MAY NOT BE DISCUSSED WITH ANYONE, EITHER INSIDE OR OUTSIDE THE Nurse Registry (EXCEPT AN NEEDED TO CONDUCT THE BUSINESS OF THE DAY). I UNDERSTAND THAT NO MEDICAL RECORDS ARE TO BE REMOVED FROM THE HOME HEALTH Nurse Registry UNLESS A "RELEASE OF INFORMATION" FORM HAS BEEN COMPLETED AND SIGNED BY THE PATIENT. IT IN MY UNDERSTANDING THAT SUCH DISCUSSION OR RELEASE OF INFORMATION IS CAUSE FOR DISMISSAL. I HAVE BEEN FORMALLY INSTRUCTED IN THE POLICIES AND PROCEDURES OF THIS HOME HEALTH Nurse Registry, ALSO INFORMED REGARDING THE Nurse Registry POLICY FOR HIPAA COMPLIANCE, AND I HAVE READ AND SIGNED A JOB DESCRIPTION FOR MY SPECIFIC CLASSIFICATION.	
PERSONAL HEALTH INFORMATION PLEDGE OF CONFIDENTIALITY _____ SIGNATURE OF INDIVIDUAL MAKING PLEDGE _____ SIGNATURE OF INDIVIDUAL ADMINISTERING PLEDGE	I, the undersigned, have read and understand the this Nurse Registry, (hereinafter "this Nurse Registry") policy on confidentiality of personal health information (PHI) as described in the Confidentiality Policy which is in accordance with relevant state and federal legislation. I also acknowledge that I am aware of and understand the Policies of the this Nurse Registry, regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage and destruction of personal health information. In consideration of my employment or association with this Nurse Registry, and as an integral part of the terms and conditions of my employment or association, I hereby agree, pledge and undertake that I will not at any time, during my employment or association with this Nurse Registry, or after my employment or association ends, access or use personal health information, or reveal or disclose to any persons within or outside this Nurse Registry, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation, and this Nurse Registry, policies governing proper release of information. I understand that my obligations outlined above will continue after my employment/contract/association/ appointment with this Nurse Registry, ends. I further understand that my obligations concerning the protection of the confidentiality of PHI relate to all personal health information whether I acquired the information through my employment or contract or association or appointment with this Nurse Registry, or with any of the entities, which have an association with this Nurse Registry If for any reason I must complete any clinical documentation of any of my patient at later time, or at my residence, I assure that no Protected Health Information will be left unattended in my vehicle. In my residence, it will be placed in a secure location where children or any family member will not have access to it at any time. All family members will be alerted about the Confidentiality status of such records. I also understand that unauthorized use or disclosure of such information will result in a disciplinary action up to and including termination of employment or contract or association or appointment, the imposition of fines pursuant to relevant state and federal legislation, and a report to my professional regulatory body.	
POLICY ON JOBS	As a Staff of this Nurse Registry, I understand that the job I am being hired to perform belongs to this Nurse Registry. I also understand that it is illegal for me to transfer or attempt to transfer any case to another Nurse Registry or take ownership of any job that I am employed in. Should I act underhandedly and take over such a job so that I may be paid directly by the client, to the exclusion of my employer, or transfer any case to another Nurse Registry. I will be in violation of State, Federal and Nurse Registry rules and will accordingly pay $10,000.00 to This Nurse Registry	

Staff/Contractor Signature: _____ Date:_____

CLARIFICATION OF CONTRACTOR STATUS

Policy: To Help clarify the "Contractor" term used in our Policy Manual and Contractor Package.
Our Registry employ only Independent Contractors.

Statutes usually fail to clearly define the term "Contractor", and no single standard to distinguish between Contractor and independent contractor has emerged.

The IRS 20-factor, right-to-control test is used to assess an employers' tax liability. A similar test is used in most states to determine status under workers' compensation laws. The so- called "economic realities test" or a hybrid of the right-to-control and economic realities test often is used by courts to determine independent contractor status in other circumstances. In essence, the economic realities test makes it harder to classify a worker as an independent contractor, because, in addition to considering the degree of control the employer exercises, it takes into account the degree to which the workers are economically dependent on the business. The economic realities test is used to determine Contractor status under the Family and Medical Leave Act (entitling workers to unpaid leave under certain circumstances), the Fair Labor Standards Act (establishing a minimum wage), and the Worker Adjustment and Retraining Act (providing for advance notice in event of plant closings and mass layoffs). Additionally, it is often applied by courts in determining independent contractor status in civil rights cases under Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, and the Americans with Disabilities Act. States use a variety of other tests to determine independent contractor status for unemployment insurance purposes.

The LEGAL definition of his/her condition is stated in the **LEGAL Agreement** signed between our Nurse registry and the staff, where we clearly state his legal condition as **"Independent Contractor"** without tax deduction.

_____ _____

Staff Name Signature

Date: _____

REFERENCE FOR POTENTIAL Contractor

Name of Applicant: _____

Address of Applicant: _____

List three (3) persons we may contact for professional references:

	Name	Address	Telephone
1.			
2.			
3.			

Date of phone contact: _____

Past employment confirmed: **Yes** **No**

Would reference re-hire? **Yes** **No**

Name of phone contact: _____

Name of staff making this call: _____

Date and time of this call: _____

agency for persons with disabilities
State of Florida

PROVIDER APPLICANT REFERENCE FORM

The applicant below has applied to become a Medicaid Waiver Provider. Your cooperation in completing this reference will greatly assist the Agency for Persons with Disabilities (APD) in determining if the applicant meets the minimum qualifications to become a Waiver Provider.

INSTRUCTIONS:

- Please type or print legibly.
- Applicants must have references from **two (2) supervisors or co-workers** who are familiar with their work in a Developmental Disability setting.
- **APPLICANT** – Complete Part I, provide this form to your references with a return self-addressed envelope. Provide the completed form from your reference with your application materials.
- **REFERENCE** – Complete Part II and return this form to the applicant in the envelope provided to you.

PART I – APPLICANT

Name:

PART II - REFERENCE

REFERENCE NAME:

ADDRESS: _____
STREET CITY STATE ZIP

PHONE:

OTHER CONTACT INFORMATION:

RELATIONSHIP TO APPLICANT: ☐ SUPERVISOR ☐ CO-WORKER

DATES OF RELATIONSHIP: FROM: _____ (MM/DD/YY) TO: _____ (MM/DD/YY)

PROFESSIONAL POSITION WHEN WORKING WITH APPLICANT:

Title:

Agency/Institution:

Address:

RECOMMENDATION:

I ☐ Recommend ☐ Do Not Recommend the Applicant for Enrollment

ADDITIONAL COMMENTS:

[Please write any comments that would assist the APD Enrollment Liaison in making a decision on this Applicant for enrollment.]

Reference Signature	Date

Form J

KM HOME CARE LLC
DOCUMENTATION STANDARDS

All employees of KM Home Care LLC (the Agency) will observe the following documentation guidelines:

- Every page in the record shall be identifiable to a specific recipient and bear the recipient's name and other Agency identifiable information, such as date of birth, etc.
- All recipient record documentation shall only be made on Agency-approved forms and documents.
- Every entry in the recipient record must include a complete date (month, day and four-digit year) and a time associated with it.
- Entries should be made as soon as possible after an event or observation is made. It is unacceptable for any Agency employee to document in advance or to back-date an entry.
- Entries must authenticated by a signature. At a minimum the signature should include the first initial, last name and title/credential.
- Documentation must be authenticated by the employee who wrote it. A employee shall never make an entry to a recipient record or sign documentation of service that has been written by someone else.
- Entries must be made in black pen, in permanent ink. No eraseable pen, water-soluble ink or pencil may be used.
- Agency employee notes shall be original documents and not photocopies.
- Documentation must be specific and based on facts and observation (i.e., things that are seen, heard, touched, smelled, signs, symptoms) and not in language that is vague or generalized. Examples of vague documentation: *"Recipient is doing well"* or *"Recipient isn't herself today."* Preferred documentation: *"Recipient is alert and oriented to time and place,"* or *"Recipient exhibits anxious behavior such as pacing for an hour at a time in the early evening, and is agitated and asking about her daughter."*
- Documentation must include all facts and pertinent information related to an event, services provided, recipient condition, response to services or information, etc.
- Documentation shall not contain abbreviations that are not generally accepted.

KM HOME CARE LLC
DOCUMENTATION STANDARDS

- If the documentation is not legible by someone other than the author, it must be rewritten by the author on the next available line, by defining what the entry is, referring back to the original documentation and legibly rewriting the entry. *Example: "Clarified entry of (date)" and rewrite entry, date and sign. The rewritten documentation must be the same as the original.*

- Standardized forms may contain questions or fields that do not pertain to a recipient. In those cases, the Agency employee will indicate that the item is not applicable by writing "N/A" to show that the question was reviewed and answered. All fields should have some entry whether they apply to the recipient or not. Blank fields may be subject to tampering or falsification by others.

- When an error is made in a recipient record entry or document, proper error correction procedures must be followed:
    - Draw line through information (thin pen line). Make sure that the inaccurate information is still legible.
    - Initial and date the corrected entry.
    - State the reason for the error (i.e. in the margin or above the note where possible).
    - Document the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available line/space documenting the current date and time and referring back to the incorrect entry.

- Agency employees may never obliterate or otherwise alter the original entry by blacking out with marker, using white out, writing over an entry, etc.

I agree to uphold the Agency's Documentation Standards.

Employee's name: (PRINT)	Signature:	Date:

Form G

KM HOME CARE LLC
CODE OF CONDUCT

As an employee of KM Home Care LLC (the Agency), I agree that I will:

- Hold paramount the safety, health and welfare of the Agency service recipients in the performance of my professional duties.
- Treat with respect and consideration all persons, regardless of race, religion, gender, sexual orientation, maternity, marital or family status, disability, age or national origin.
- Engage in carrying out the Agency's Mission in a professional manner.
- Demonstrate the highest standards of personal integrity and honesty in all activities.
- Avoid any interest or activity that is in conflict with the conduct of my obligations to the Agency and the Agency's recipients.
- Respect and protect privileged and confidential information of the Agency and its recipients.
- Report any fraud, abuse neglect or other illegal or immoral behavior which would harm or injure any Agency recipient, staff member or the Agency.
- Refrain from unethical, illegal or immoral behavior which would harm or injure any Agency recipient, staff member or the Agency.

I also understand that I may not:

- Use, for marketing or solicitation purposes, information from any source that identifies recipients receiving waiver services;
- Solicit recipients to request services directly or through an agent, through the use of fraud, intimidation, undue influence or any form of overreaching;
- Unduly influence a recipient to request a service, select a service Agency, or participate in an activity regardless of whether the recipient's request results in selection to the Agency;
- Compensate a recipient with funds or any item of value for the purposes of inducing the recipient to select the Agency for services or for any matter related to the provision of services.
- Receive any financial benefit as a result of being named the beneficiary of a life insurance policy covering a recipient served by the Agency.
- Benefit financially by borrowing or otherwise using the personal funds of a recipient served by the Agency.

I agree to uphold the Agency's Code of Conduct.

Staff member's name: (PRINT)	Signature:	Date:

KM Home Care LLC

Employee Name: _____

STAFF CODE OF CONDUCT/ETHIC

To outline a standard of conduct for all employees, contractors and members of the Board of Directors. To establish and retain the highest possible level of public confidence.

CODE OF ETHICS:

- The Code of Ethics contains standards of ethical behavior and practices that impact all dealings with colleagues, patients, the community and society as a whole.
- The Code of Ethics also incorporates standards governing personal behavior particularly when that conduct directly relates to the role and identity of the organization.
- The Code of Ethics outlines principles focused on maintaining and enhancing excellence within OUR Registry
- The Code of Ethics serves as notice to government officials that OUR Registry expects its personnel to abide by all applicable laws and regulations.
- OUR Registry has an ethical responsibility to the patients and the community it serves, and fulfills this responsibility through ethical care, treatment, services and business practices.
- Whenever possible, patients/families/legal guardians are included in decisions about the patients' care, treatment and services, including ethical issues.
- Should the patient require or request care, treatment or services not available or inconsistent with the organization's mission, an offer to refer/transfer the patient to an organization that can fulfill this need will be made and if in agreement, the patient will be referred/transferred appropriately.
- The patient/family will be notified of any financial benefit, if any, to OUR Registry as a result of the referral/transfer process.
- Contracted providers/staff of healthcare services must meet and adhere to the quality and ethical standards of this organization.
- Billing practices of OUR Registry shall adhere to and be compliant with usual and acceptable standard ethical and legal business billing practices.
- The effectiveness and safety of care, treatment and services provided by OUR Registry is consistent for all patients and is not dependent on the patient's ability to pay.

STAFF MEMBERS' AND BOARD OF DIRECTORS' RESPONSIBILITY TO THE ORGANIZATION:

- Uphold the values, ethics and mission of the organization.
- Conduct all personal and professional activities with honesty, integrity, respect, fairness and good faith in a manner that will reflect positively upon the organization and in the best interest of the patient population and community served.
- Comply with all applicable local, state and federal laws and regulations in the conduct of organizational or personal activities.
- Respect confidences including confidential business information.
- Assure that no conflict of interest exists in any dealings involving the organization.
- Provide healthcare services consistent with available resources and assure the existence of a resource allocation process that considers ethical ramifications.
- Respect of the customs and practices of those served, consistent with the organization's philosophy.
- Be truthful in all forms of communication, including receivables and avoid information that would create unreasonable expectations.
- Assure the existence of a process to evaluate the quality of care or services rendered.
- Avoid practicing or facilitating discrimination and institute safeguards to prevent discriminatory organizational practices.
- Advise patient of rights, responsibilities and risks regarding care and services provided.

VIOLATIONS: Employees, Administrators and volunteers who violate this code shall be subject to disciplinary action, up to and including termination of employment.

Employee/Contractor Signature: _____ Date: _____

KM HOME CARE LLC

STAFF CONFLICT OF INTEREST

PURPOSE:

To ensure Contractors avoid any personal interest that may conflict with the interests of the nurse registry.

POLICY:

The Nurse registry expects all of its Contractors to understand and be aware of potential situations where their personal interests may conflict with the business interests of the Nurse registry.

PROCEDURE:

1. All Contractors will report to their immediate supervisor any interests in or employment with an entity that interacts with the Nurse registry including, but not limited to:
    - A. Contractor participation in any business transactions where there might appear to be a conflict between the Contractor's personal interest and that of the Nurse registry.
    - B. Contractor participation in any entity which buys services from or provides services/products to the Nurse registry.
    - C. outside employment that interferes with satisfactory performance of an Contractors duties and responsibilities for the Nurse registry.
    - D. any outside relationship, financial interest, or participation in a business transaction which might appear to influence the performance of an Contractor's duties and responsibilities for the Nurse registry.
    - E. Acceptance of gifts, including cash payments, fees, services, discounts, valuables, privileges or other favors which would or might appear to improperly influence an Contractor in the performance of the Contractor's duties and responsibilities for the Nurse registry.
2. If a conflict of interest is discovered or suspected the supervisor/manager and Contractor will discuss its impact with the Administrator.
3. After the above discussion, a recommendation may be made for the Contractor to end his/her association with the entity or the Nurse registry within a specified period of time.
4. The failure of an Contractor to cease activity that management determines to be a conflict interest will subject the Contractor to disciplinary action up to and including termination.
5. Upon hire, nurse registry staff will sign a Conflict of Interest Statement.

_____ _____

Staff Signature Date

STATEMENT OF PRINCIPLE RELATING TO DISCLOSURE OF CONFLICTS OF INTEREST

No Contractor or member of the Board of Directors, or other individual committee, or entity shall derive any profit or gain directly or indirectly by reason of their association with the Nurse registry, without the prior knowledge and approval of the Board of Directors. All board members and/or Contractors, at the discretion of the board, will be required to submit a disclosure statement annually.

Full and prompt disclosure to the Board of Directors will be made of any transaction, situation, or event which may place a person(s) in a position in which his or her family, partner or business associate is in conflict with the interest of the Nurse registry.

Full disclosure will be made of the names and addressed of individuals or corporations having a combined direct or indirect ownership or controlling interest of 5 percent or more in the Nurse registry or in any subcontractor in which the Nurse registry has a direct or indirect ownership interest of 5 percent or more.

Disclosure must be made of conviction of any criminal offense involving Medicare, Medicaid or Title XX programs on the part of any person on the Board of Directors and on the part of any agent or managing Contractor of the Nurse registry.

Disclosure must be made of the names and addresses of any current Contractors in managerial, accounting, auditing, or similar capacity who were employed by the Nurse registry's any fiscal intermediary within the previous twelve months.

Change of address for parent, subunits or branches must be promptly disclosed.

Purchases, sales, leases or other contractual arrangements to, from and with the Corporation shall, except as hereinafter specified, be considered as involving potential conflict, which should be disclosed.

Gifts or other favors offered, or received, shall be disclosed.

No officer, Director or Contractor of the Corporation shall have any personal financial interest, direct or indirect, in any contract relating to the business conducted by the Corporation, or the furnishing of supplies or equipment to the Corporation, unless authorized by the concurring vote of two-thirds of the Board of Directors.

In matters involving a conflict of interest, a board member must disclose any known significant reasons why a transaction might not be in the best interest of the Nurse registry and a board member shall not participate in discussions unless requested by the board not vote on such transactions. The abstention and the reason for it shall be recorded in the minutes.

A director, officer or Contractor in a policy making position of the Corporation will not, however, be considered to have a conflict of interest with the Corporation if he/her or any member of his/her family:

1. Is an officer, director or Contractor of a Bank, Savings and Loan Association, or company in which the Corporation has funds on deposit or invested in shares of stock:
2. Is or has been employed (or a member of his family or partner is or have been employed) with the approval of the Board of Directors to render legal, accounting, or other professional services to the Corporation on a fee basis.

KM HOME CARE LLC

INDIVIDUAL STATEMENT REGARDING CONFLICT OF INTEREST (Board of Directors)

I have read and am fully familiar with the Nurse registry's policy statement regarding conflict of interest. I am not presently involved in any transaction, investment, or other matter in which I would profit or gain directly or indirectly as a result of my membership on the Nurse registry's Board of Directors or its committees or my employment. Furthermore, I agree to disclose any such interest which may occur in accordance with the requirements of the policy and agree to abstain from any vote or action regarding the Nurse registry's business that might result in any profit or gain, directly or indirectly, for myself.

_____

Signature

_____

Date

KM Home Care LLC

ORIENTATION PROGRAM HHA/CNA

NAME:_____ DATE OF EMPLOYMENT: _____

POSITION: _____

I:	DATE	SIGNATURE
1. Job Description		
2. Contractual Items		
3. Orientation of Registry (Philosophy, Policies, Organization Chart)		
4. Time slips for services Provided		
5. Developing Plan of Treatment		
6. Daily Report and Clinical Notes Requirement		
7. Lines of Communication & Supervision		
8. Visit Defined		
9. Case Conference		
10. Mileage		
11. Safety Management		
12. Infection Control		

II:	DATE	SIGNATURE
1. Introduction to Office Personnel		

III:	
1. Personnel Policies Review & Discussion Payroll Procedure	
2. Schedule of Pay, Time, Hours of Work	
3. Coordination of Services	
4. Dress Code	
5. Insurance Benefits	
6. Reporting Illness	
7. Staff in-service meetings	

IV:	
1. Field Assignments Days and Type of Patient Services, Pain Rating	
2. Criteria of Admission of Patients to Nurse Registry	
3. Completion of necessary form for admission to service	
4. Skilled care vs. non-skilled	

KM Home Care LLC

Conbtractor Name:_____

SESION TWO: **DATE** **SIGNATURE**

I. Discussion of Referral Sources

1. Hospital: Social worker, liaison discharge planner _____
2. Doctor _____
3. Family _____
4. Social Agencies (ie. HRS) _____
5. Staff _____

II.

1. Hospital: Social worker, liaison, discharge planner _____
2. Contractual agreement with Rn's _____
3. Contractual agreement w/LPN's _____
4. Contractual agreement with HHA _____

III. Regulations governing unskilled staff:

1. Type of care to be provided _____
2. Supervision of care _____
3. Necessary unskilled staff forms _____

IV.

1. Format of Documentation of services provided to patient. _____
2. Charting for Registry patients _____
3. Charting to contract Nurse Registry _____

V. Discharge of patients from Nurse Registry _____

VI. Explanation of the role of supervisor and the methods which will be used for evaluating Performance and identifying needs. Emergency Preparedness. _____

Also I was oriented about: Patient's Rights, Advance Directives, Professional Boundaries, Registry's Performance Improvement Plan, Incident/Variance reporting.

I HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF THE Registry AND HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY QUESTIONS/CONCERNS ADDRESSED TO MY COMPLETE SATISFACTION.

I AGREE TO ABIDE AND UPHOLD ALL POLICIES AND PROCEDURE, AND HAVE BEEN ADVISE THAT FAILURE TO DO SO MAY RESULT IN TERMINATION OF EMPLOYMENT.

I ALSO AGREE THAT AS A CONDITION OF EMPLOYMENT THAT I WILL PROVIDE THE Registry WITH A FOURTEEN (14) DAY WRITTEN NOTICE OF INTENT TO TERMINATE EMPLOYMENT.

_____ _____

Contractor SIGNATURE/TITLE (HHA/CNA) **DATE**

_____ _____

WITNESS SIGNATURE **DATE**

CLARIFICATION OF CONTRACTOR STATUS

Policy: To Help clarify the "Contractor" term used in our Policy Manual and Contractor Package.
Our Registry employ only Independent Contractors.

Statutes usually fail to clearly define the term "Contractor", and no single standard to distinguish between Contractor and independent contractor has emerged.

The IRS 20-factor, right-to-control test is used to assess an employers' tax liability. A similar test is used in most states to determine status under workers' compensation laws. The so- called "economic realities test" or a hybrid of the right-to-control and economic realities test often is used by courts to determine independent contractor status in other circumstances. In essence, the economic realities test makes it harder to classify a worker as an independent contractor, because, in addition to considering the degree of control the employer exercises, it takes into account the degree to which the workers are economically dependent on the business. The economic realities test is used to determine Contractor status under the Family and Medical Leave Act (entitling workers to unpaid leave under certain circumstances), the Fair Labor Standards Act (establishing a minimum wage), and the Worker Adjustment and Retraining Act (providing for advance notice in event of plant closings and mass layoffs). Additionally, it is often applied by courts in determining independent contractor status in civil rights cases under Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, and the Americans with Disabilities Act. States use a variety of other tests to determine independent contractor status for unemployment insurance purposes.

The LEGAL definition of his/her condition is stated in the **LEGAL Agreement** signed between our Nurse registry and the staff, where we clearly state his legal condition as **"Independent Contractor"** without tax deduction.

_____ _____

Staff Name Signature

Date: _____

Form Y

KM HOME CARE LLC
ORIENTATION CHECKLIST

Employee's Name: _____ Date: _____

By signing below, I acknowledge that I have been oriented on the following:

Covered	Topic
☐	Person-centered philosophy of care, Code of Conduct (Form G)
☐	Provision of services & chain of command
☐	Visit notes, Documentation Standards (Form J), documentation guidelines & deadlines
☐	Confidentiality & security of recipient information
☐	Incidents, grievances & events requiring notification
☐	Infection control & Exposure Control Plan
☐	Scope of services
☐	Emergency measures
☐	Other:

Confidentiality Policy and Agreement - I agree to:

- Maintain recipient confidentiality according to HIPAA standards and all other healthcare privacy legislation, even after my contract with KM Home Care LLC is terminated.

- Refrain from discussing any recipient's information or the organization's business with anyone who does not work with or for KM Home Care LLC, and who does not have a need to know about the information or business. I will refer any individuals making such inquiries to the Supervisor.

- Maintain the confidentiality of trade secrets, confidential or proprietary information regarding the organization's APD recipients or business.

Employee's signature:	Date:
Orientation conducted by:	Date:

KM Home Care LLC

Registry ZERO FRAUD TOLERANCE POLICY

PURPOSE:
To ensure staff participate in the Nurse Registry effort to avoid/prevent any FRAUD activity that may conflict with the interests of the Nurse Registry, and any State/Federal/Private programs.

POLICY:
The Nurse Registry expects all of its staff to understand and be aware of potential situations where the FRAUD will be not tolerated.

PROCEDURE:

1. All staff will report to their immediate supervisor any actions/omission in/or employment, services that interacts with the Nurse Registry Fraud prevention Policy, but not limited to:
    - A. Staff participation in any business transactions where there might appear to be a conflict between the staff personal interest and that of the Nurse Registry effort to prevent fraud.
    - B. Staff participation in any activity/cover for services not provided.
    - C. Outside employment that interferes with satisfactory performance of an staff duties and responsibilities for the Nurse Registry.
    - D. Any outside relationship, financial interest, or participation in a business transaction which might appear to influence the performance of an staff duties and responsibilities for the Nurse Registry.
    - E. Acceptance/giving of gifts, kick back, including cash payments, fees, services, discounts, valuables, privileges or other favors which would or might appear to improperly influence an Staff in the performance of the staff duties and responsibilities for the Nurse Registry. (Illegal remuneration)
    - F. Participated in any action to Alter Costs.
    - G. Use un-licensed person to perform their duties, or licensed without authorization (misrepresentation).
    - H. Not report any sign of Abuse: verbal, physical, economical or any other form.
    - I. Participate in any act of Identity/Insurance ID theft.
    - J. Permit unnecessary or Duplicate services.
    - K. Altering Claims, Billing forms, Invoices, Expenses, or any other accounting related issue. (Over-billing)
    - L. Non-compliance with approved/ordered scheduled of visits, and Reporting Guidelines, including technically corrected transcribing services if used.
    - M. Participate in fraudulent Records, Notes, Signatures, Reports.
2. If a fraud action is discovered or suspected the supervisor/manager and Staff will discuss its impact with the Administrator.
3. After the above discussion, a recommendation may be made for the Staff to end his/her association with the entity or the Nurse Registry within a specified period of time, including the correspondent report to any Regulatory Nurse Registry.
4. The failure of an Staff to cease activity that management determines to be a fraud action will subject the Staff to disciplinary action up to and including termination.
5. Upon hire, Nurse Registry staff will sign a Nurse Registry Zero Fraud Tolerance Statement.

Staff Name & Title: _____

_____ _____

Staff Signature Date

KM HOME CARE LLC

INFECTION CONTROL ACKNOWLEDGMENT

DATE: _____

Contractor NAME: _____

Contractor SOCIAL SECURITY: _____

POSITION: _____

I hereby acknowledge that I have read and understand the Infection Control Policy contained in the Field Contractors Procedure Manual. I am familiar with the procedures appropriate to my position as a field Contractor.

Contractor SIGNATURE: _____

ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING FORM

I hereby acknowledge that I have received a copy of Our Agency Drug-Free Workplace Program. I understand that it is my responsibility to read the policies and procedures contained in the Program and question my supervisor regarding any aspect of the Program that compliance with the policies and procedures contained in the program is a condition of employment with our Agency.

I further understand that the policies and procedures contained in the Program constitute statements of policy only, and re not to be interpreted as a contract of employment between the company and me. I also understand that the Company reserves the right to change, modify, or delete any of its policies and procedures in the Program at any time.

PRINT NAME (EMPLOYEE)

SIGNATURE OF EMPLOYEE (DATE)


KM Home Care LLC

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Acknowledgment

I, _____ acknowledge that I received the "New Health Insurance Marketplace Coverage Options and Your Health Coverage" exchange notification on _____.

I agree to review the notice provided. I understand that if I have any questions or if I encounter any problems, I can contact the Administrator.

_____	_____	_____
Staff Name	Signature	Date

Reconocimiento

Yo, _____ reconozco que he recibido la forma de " Nuevas opciones de cobertura en el mercado de seguros médicos y su cobertura médica" el _____.

Estoy de acuerdo en revisar el aviso. Entiendo que si tengo alguna pregunta o si me encuentro con problemas, puedo contactar al Administrador.

_____	_____	_____
Nombre de empleado	Firma	Fecha

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

TRANSPORTATION RESPONSIBILITY

Our Nurse registry will carries the appropriate amount of insurance on all company vehicles (if any). The Nurse registry's insurance carrier will instructs the company on what is an appropriate amount of insurance based on risk assessments and in compliance with state laws and Nurse registry's Policy. Personnel follows the Nurse registry's policies and procedures for the appropriate amount of insurance on personal vehicles used in the provision of care/service.

TRANSPORTATION RESPONSIBILITY CONTRACT

It has been explained to me that I am being offered employment by KM Home Care LLC with the understanding that I have personal transportation at my disposal to be used for travel to and from the patient assignments. I further understand that I am responsible for auto liability of $ 10,000.00 / $ 20,000.00 for bodily injury and $ 5,000.00 in property damage.

I will not use my own car to transport Patients/Clients.

_____ _____

Contractor'S SIGNATURE **DATE**

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. An alien authorized to work until (exp. date, if any) _____

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2 within three** business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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, sex, 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, sex, 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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See *Specific Instructions* on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check **only one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under **penalties** of perjury, I certify that:

1. The **number** shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am **not subject** to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition **or abandonment** of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other **than interest** and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | **Signature of U.S. person** | **Date**

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting*, later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code*, later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships*, earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code*, later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester*, later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code*, earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships*, earlier.

*Note: The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint*. You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

KM Home Care LLC

TAX EXEMPT FORM

I, _____ hereby acknowledge that I am an Independent Contractor. Therefore, I am responsible for my social security and other taxes, and will receive an IRS 1099 Form for the preceding year by February of each year which is also sent to the Internal Revenue Services (IRS).

_____ _____

Signature Date

_____

Social Security number

_____

Position

EMERGENCY TELEPHONE NUMBERS

I, _____, have been instructed by *KM Home Care.* to maintain this document in a safe place. I also understand that these numbers are given to me to call **only** in case of emergency or if assistance is needed. I will also report any changes or emergencies to my Waiver Support Coordinator.

In Case of a Medical Emergency: Please call "911"

Important numbers to call in case of Emergency:	
American Red Cross	**(305) 644-1200**
Miami-Dade Sheriff's Office	**(305) 471-1780**
Crime Stoppers	**(305) 471-8477**
Emergency Preparedness	**(305) 468-5400**
Poison Control Center	**1-800-222-1222**
Emergency Management Division	**1-800-955-8771**
Evacuation Assistance	**(305) 513-7700**

To report abuse, neglect and/or exploitation: Please call **1-800-96ABUSE** (1-800-962-2873). This number is available 7 days a week, 24 hours a day.

To report fraud: Please call **1-866-APD-CARES** (1-866-273-2273) or visit www.apd.myflorida.com.

To report a complaint about the services you receive: Please call 1-888-419-3456.

To report suspected Medicaid Fraud: Please call 1-866-966-7226 or visit the Agency for Health Care Administration website at http://ahca.myflorida.com/Executive/Inspector_General/complaints.shtml.

***Medicaid Fraud* means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person, as well as any at that constitutes fraud under applicable federal or state law as it relates to Medicaid.

KM Home Care., offers an emergency on-call system 24 hours, 7 days a week.

I understand my right to report any **Abuse, Neglect or Exploitation** I am personally subject to, and my responsibility to report any abuse that I see or know.

_____ _____
Individual receiving services/Guardian Signature Date

_____ _____
KMHC Services Representative Date

FOR OFFICIAL USE ONLY

Client Copy: ☐ **given in person** ☐ **mailed to home address**

On _____ from: _____
(Date) (Emp. Signature)

Alzheimer Resource Center of Tallahassee, Inc.

AFA Alzheimer's Foundation of America

Prepared by the Florida Health Care Association with the assistance of the Alzheimer Resource Center of Tallahassee, Florida to meet the statutory requirement of 400.4785(1) (a) F.S.

ALZHEIMER'S DISEASE (AD) AND RELATED DEMENTIAS

History

Alzheimer's disease (AD) was first discovered in 1906 by a German doctor named Alois Alzheimer. It is a disorder of the brain, causing damage to brain tissue over a period of time. The disease can linger from 2 to 25 years before death results. AD is a progressive, debilitating and eventually fatal neurological illness affecting an estimated 4-5 million Americans. It is the most common form of dementing illness.

Alzheimer's disease is characterized clinically by early memory impairment followed by language and perceptual problems. This disease can affect anyone - it has no economic, social, racial or national barriers.

Causes

There is no one cause for Alzheimer's disease. AD may be sporadic or passed through the genetic make-up. The disease causes gradual death of brain tissue due to biochemical problems inside individual brain cells. The symptoms are progressive, but there is great variation in the rate of change from one person to another. Although in the early stages of Alzheimer's the victim may appear completely healthy, the damage is slowly destroying the brain cells. The hidden process damages the brain in several ways:

- Patches of brain cells degenerate (neuritic plaques)
- Nerve endings that transmit messages become tangled (neurofibrillary tangles)
- There is a reduction in acetylcholine, an important brain chemical (neurotransmitter)
- Spaces in the brain (ventricles become larger and filled with granular fluid)
- The size and shape of the brain alters - the cortex appears to shrink and decay

Understandably, as the brain continues to degenerate, there is a comparable loss in mental functioning. Since the brain controls all of our bodily functions, an Alzheimer victim in the later stages will have difficulty walking, talking, swallowing and controlling bladder and bowel functions. They become quite frail and prone to infections such as pneumonia.

Dementia vs. Normal Aging

As a person grows older, he/she worries that forgetting the phone number of a best friend must mean he/she is becoming demented or getting Alzheimer's disease. Forgetfulness due to aging or increased stress is *not* normal aging and is *not* dementia.

"Dementia" is an encompassing term for numerous forms of memory loss. There are many types of dementia such as Alzheimer's disease, Multi-Infarct dementia or Parkinson's disease. When a person has dementia, he/she will lose the ability to think, reason and remember and will inevitable need assistance with everyday activities such as dressing and bathing. Changes in personality, mood are also symptoms of dementia. Many dementias are treatable and reversible. Alzheimer's disease is the most common form of untreatable, irreversible dementia.

Alzheimer's Disease - Stages of Progression

Alzheimer's Disease can be characterized as having early, middle, and late stages through which the patient gradually progresses, but not at a predictable rate. The range of the course of the disease is 2-25 years. NOTE: Stages very often overlap. Everyone progresses through these stages differently.

First Stage: This is a very subtle stage usually not identified by either the impaired person or the family as the beginning signs of the disease. Subtle changes in memory and language along with some confusion occur at this time. The family usually denies or excuses the performance deficiencies at this stage.

- Forgetfulness/memory loss
- Impaired judgment
- Trouble with routines
- Lessening of initiative
- Disorientation of time and places

- Depression
- Fearfulness
- Personality change
- Apraxia (forgetting how to use tools and equipment)
- Anomia (forgetting the right word or name of a person)

Second Stage: As Stage 1 moves onto Stage 2, there is usually a particular significant event which forces the family (and impaired person) to consider that something is really wrong. At this time, they usually go to a doctor to diagnose the problem.

- Poor short-term memory
- Wandering (searching for home)
- Language difficulties
- Increased disorientation
- Social withdrawal
- More spontaneity, fewer inhibitions
- Agitation and restlessness, fidgeting, pacing
- Developing inability to attach meaning to sensory perceptions: (taste, touch, smell, sight, hearing)
- Inability to think abstractly
- Severe sleep disturbances and/or sleepiness
- Convulsive seizures may develop
- Repetitive actions and speech
- Hallucinations
- Delusions

Third (Final Stage): This stage is the terminal stage and may last for months or years. The individual will eventually need total personal care. They may no longer be able to speak or recognize their closest relatives.

- Little or no memory
- Inability to recognize themselves in a mirror
- No recognition of family or friends
- Great difficulty communicating
- Difficulty with coordinated movements
- Becoming emaciated in spite of adequate diet
- Complete loss of control of all body functions
- Increased frailty
- Complete dependence

COMMON PROBLEMS WITH DEMENTIA

Delusions

Suspiciousness: accusing others of stealing their belongings
People are "out to get them"
Fear that caregiver is going to abandon (results in AD person never leaving caregiver's side)
Current living space is not "home"

Hallucinations

Seeing or hearing people who are not present

Repetitive actions or questions

They forget they asked the question
Repetitive action such as wringing a towel

Wandering

Pacing
Sundowning: trying to get "home"
Generally feeling uncomfortable or restless
Increased agitation at night

Losing thing/Hiding things

Simply do not remember where items are
Might hide things so that people don't "steal" them

Inappropriate sexual behavior

Person with AD loses social graces and is only doing what feels good

Agnosia: inability to recognize common people or objects

A wife of forty years will become a stranger to the person with AD, he might even think she is the hired help

Might not recognize a spatula or the purpose of the spatula and/or cannot verbalize the name or purpose of the object

Apraxia: loss of ability to perform purposeful motor movements

Cannot tie a shoe or manipulate buttons on a shirt

Catastrophic reactions

(Causes) AD person often becomes excessively upset and can experience rapidly changing moods. The person becomes overwhelmed due to factors such as too much noise, too many people around, unfamiliar environment, routine change, being asked to many questions, being approached from behind.

(Reactions) AD person may become angry, agitated, weepy, stubborn or physically violent. It is best to attempt to avoid catastrophic reactions rather than dwell on how to handle them.

HANDLING DISTURBING BEHAVIORS

One of the most difficult challenges for caregivers is how to handle some of the disturbing behaviors that Alzheimer's can cause. Symptoms such as delusion, hallucinations, angry outbursts, suspiciousness, failure to recognize familiar people and places are often the most upsetting behaviors for families. The following points may help in responding to disturbing symptoms.

First, try to understand if there is a precipitating factor causing the behavior. Were there household changes, too much noise or activity, was the daily routine upset? Time of day can also affect behavior (Sundowning). Being aware of these factors can help to better plan activities or anticipate problems.

1. Keep tasks, directions and routine simple without being condescending
2. Always give the person plenty of time to respond
3. Attempt to remain calm and remind yourself that the behavior is due to the disease
4. Avoid arguing
5. Write down the answers to frequently asked questions, then remind them to look at the message
6. Reduce environmental noise: television, radio, too many people talking
7. Use distraction when unacceptable behavior starts: bring them into a different room, start talking about childhood or another favorite topic, show them magazines, ask them to help you do something like dusting or sweeping
8. Do not overreact or scold for problem behavior: redirect or distract
9. Be reassuring with touch, eye contact and tone of voice
10. Find the familiar: old pipe, favorite chair, family pictures
11. Avoid denying hallucinations: try non-committal comments like, "You spoke with your mother, I miss my mother too"
12. Be sure to inform physician of hallucinations, no matter how tame
13. Restless behavior or pacing is usually unavoidable, however you can make the environment safe by installing locks that are above reach, remove unnecessary obstacles, make sure the person is wearing some kind of identification