APD Course

Requirements for all Waiver Providers

Course Sections

1. Medicaid Waiver Information.
2. Key Provider Requirements and Best Practices
3. Compliance with Federal and State Laws
4. Zero Tolerance Overview
5. Incident Reporting
6. Medication Administration and Behavior Emergency Procedures Overview
7. Key Contacts

Section 1

Medicaid Waiver Information

Medicaid

- Medicaid coverage to low income individuals and families
- State and federal government share the cost the Medicaid program
- Florida Medicaid administered by the Agency for Health Care Administration (AHCA)
- Agency for Persons with Disabilities (APD) operates the iBudget Waiver

Medicaid Waiver

What is a Medicaid Waiver?

- Long term care services are community based
- Non institutional care
- Allows state to waive certain Medicaid requirements

HCBS Federal Rule

- Ensures Community-Based Services
- Home-like Environment
- Emphasis on Personal Choice of the Client
- http://ahca.myflorida.com/Medicaid/hcbs_waivers

iBudget

- iBudget Waiver services approximately 30,000 clients
- Waiver Support Coordinators help individuals choose services and providers
- Social, medical, behavioral, residential, and therapeutic services

iBudget

Settings:

- Family Home
- Own Home
- Licensed Residential Facility

Service authorized based on:

- Client preference
- In accordance with state and federal Medicaid requirements

Services

Eight Service Families in iBudget

Service Family 1	Life Skills Development
Service Family 2	Supplies and Equipment
Service Family 3	Personal Supports
Service Family 4	Residential Services

iBudget Florida

Services

Eight Service Families in IBudget Cont'd

Service Family 5	Support Coordination
Service Family 6	Therapeutic Supports and Wellness
Service Family 7	Transportation
Service Family 8	Dental Services

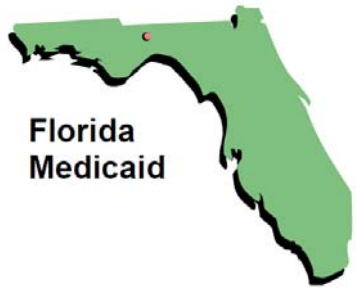
iBudget Florida

Section 2

Key Provider Requirements and Best Practices

iBudget Handbook

http://portal.flmmis.com/



DEVELOPMENTAL DISABILITIES
INDIVIDUAL BUDGETING WAIVER SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
Agency for Health Care Administration

Enrollment

- Complete background screening
- Submit APD Application
- Complete Medicaid Provider Enrollment
- Execute Medicaid Waiver Services Agreement

Enrollment

http://apdcares.org/providers/enrollment/

Provider Types

- Solo
- Agency
- Group (WSC Agencies Only)

Solo Provider

- Personally renders services
- Does not employ others to render services
- Bills at the solo rate

Agency Providers

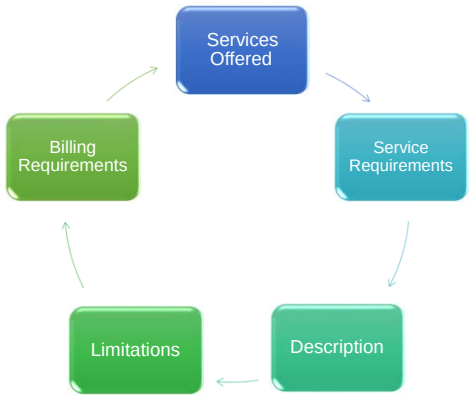
Agency Providers

- Business or organization with two or more employees providing waiver services, including the owner
- Provider that hire subcontractors only to perform waiver services cannot bill at the Agency rate
- Bills at the Agency rate

Qualifications

- Education
- Experience
- Training
- Background Screening

iBudget



Medical Necessity

- Ensures Medicaid service meets the individual's need
- Ensures services are consistent with rules
- State and federal Medicaid requirement

Billing Requirements

- Providers cannot bill when clients are not in attendance unless noted in the description of the service
- Providers cannot bill for more than one service to the same client at the same time unless authorized by APD
- Providers must render service in accordance with their service authorizations

Billing Requirements

A Provider must Supervise the provision of, and be responsible for, goods and services that:

- Have been provided to the recipient by the provider prior to submitting the claim
- Provider is licensed, certified, or enrolled to provide the service
- The service is medically necessary
- The provider ensures the quality of services

Billing Requirements

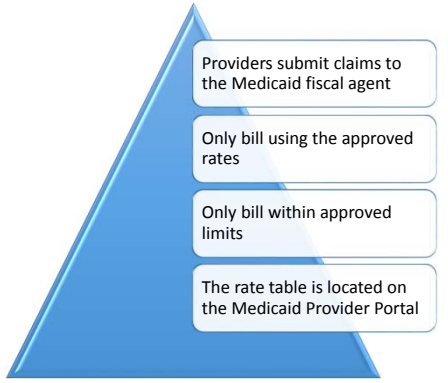
Providers must ensure that the claims are:

Not billed in whole or in part to a recipient or their responsible party

Provided in accordance to Medicaid rules, regulations, handbooks, and policies

Documented in the records

Billing Requirements



Medicaid Handbooks

http://portal.flmmis.com/

Service Authorization

- Providers must have a service authorization to bill for iBudget Waiver Services.
- Service authorizations identify the provider, amount, duration, scope, frequency, and intensity of service.

Support Plan

- Individualized plan of supports and services to meet the client's needs
- Identifies services that will be rendered by the provider, along with goals and client preferences about those services
- Helps achieve defined outcomes in an integrated community setting, ensure delivery of services that reflect client choice, ensures health, safety, and welfare

Support Plan

Person Centered Planning

The Provider will:

1. Implement person-centered supports and services
2. Support development of informed choices
3. Enhance service delivery
4. Make improvements in the provider's service delivery system

Documentation

- Service Logs
- Daily Attendance Logs
- Implementation Plan
- Quarterly Summary
- Daily Progress Notes

MWSA

Contract between APD and providers of waiver services

Providers may not bill for waiver services without a signed, current, and executed Medicaid Waiver Services Agreement.

Self Assessment

What is a Provider Self Assessment?

- Evaluation completed by the provider reviewing organization capabilities for meeting Client outcomes or goals and the service requirements
- Includes review of internal policies and procedures
- Provider can ensure quality services

Section 3

Compliance with Federal and State Laws

Florida Statutes

Chapter 393, F.S.

http://www.leg.state.fl.us

Bill of Rights

The Bill of Rights for Persons with Developmental Disabilities

- Right to dignity, privacy and humane care, including freedom from abuse, neglect, exploitation
- Right to religious freedom and practice
- Right to receive services within available sources which protect personal liberties

Bill of Rights

The Bill of Rights for Persons with Developmental Disabilities

- Right to a quality education and training services
- Right to social interaction and community participation
- Right to physical exercise and recreational opportunities

Bill of Rights

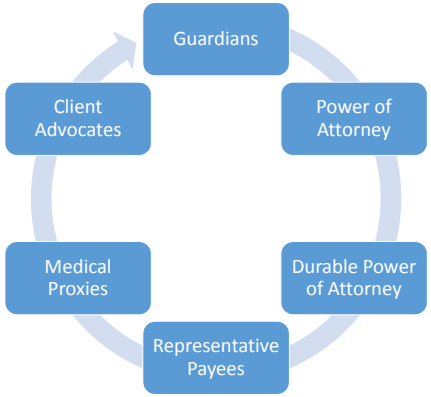
The Bill of Rights for Persons with Developmental Disabilities

- Right to be free from harm, including unnecessary restraint, isolation, excessive medication, abuse, or neglect
- Right to consent to or refuse treatment
- Shall not be excluded from participation in, or be denied benefits, or subject to discrimination
- Shall not be denied the right to vote in public elections

Other Regulations

- Title 42, Code of Federal Regulations
- Rehabilitation Act of 1973
- Title VI of the Civil Rights Act of 1964
- The Americans with Disabilities Act (also known as the ADA)
- Chapter 760, Florida Statutes is known as the Florida Human Relations Act

Legal Representative

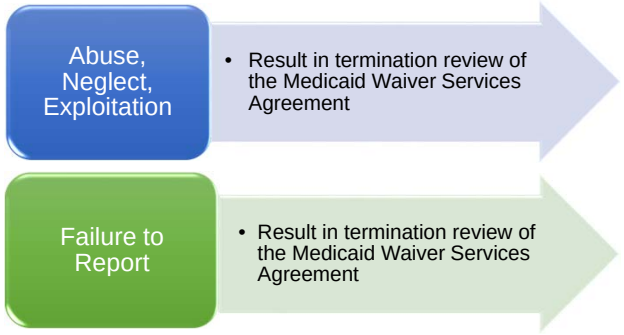


Section 4

Zero Tolerance

A statewide initiative to end abuse, neglect & exploitation

Zero Tolerance



Zero Tolerance

Known or suspected abuse, neglect, or exploitation must also be reported immediately to the Florida Abuse Hotline at:

1-800-96-ABUSE (1-800-962-2873)

TDD Access 1-800-453-5145

Zero Tolerance

Sexual activity between a direct service provider or employee and a person with a developmental disability (to whom services are being rendered) is a crime.

Section 5

Incident Reporting

Incident Reporting

What is an Incident?

An incident is an occurrence which could potentially impact the health, safety and well-being of a client of APD and must be reported to APD.

Incident Reporting

- Providers are responsible for reporting incidents involving APD clients to the Region office as they occur, but no later than the next business day.
- Providers must report incident reports and follow up reports to the APD Regional office.
- Incident Report and Follow up Form: www.apdcares.org/providers/incident-reporting/
- Providers must take immediate action to the resolve the situation.

Categories

Examples of Critical and Reportable Incidents

Critical Incidents

Unexpected Client Death

Unexpected client death that occurs due to an accident, act of abuse, neglect or other unexpected incident.

Examples:

- Homicides
- Motor Vehicle Accidents
- Accidental Drug Overdoes
- Heart Attack, Stroke, Trauma
- Sudden death
- Rapid deterioration

Critical Incidents

Life Threatening Injury

- Severe Injuries
- Substantial Risk of Death
- Loss of or substantial impairment of body

Critical Incident

Sexual Misconduct

Any sexual activity between a client and provider is sexual misconduct, regardless of whether the client consented.

Other incidents of nonconsensual sexual activity between clients or others is also sexual misconduct.

Critical Incident

Missing Child or Adult Who Has Been Adjudicated Incompetent

- Missing for more than one hour
- Please provide a case number from law enforcement in the Incident Report

Critical Incident

Media Involvement

Unusual occurrence with unfavorable media attention

Client Arrest

Arrest of a client due to a violent crime

Verified Abuse, Neglect, or Exploitation

Always report any circumstance where the Department of Children and Families verifies Abuse, Neglect, or Exploitation by the provider or staff of a provider.

Reportable Incidents

Expected Client Death

Death a result of long-standing or progressive medical condition

May be age-related

Altercation

Physical confrontation between either:

- Client and member of community
- Client and provider
- Two or more clients while services are rendered

Reportable Incident

Client Injury

Non-life threating injury received during service provision

May be due to an accident, act of abuse, neglect, or other incident while receiving services

Reportable Incident

Missing Competent Adult –

Absence or unknown whereabouts beyond eight hours of a legally competent adult receiving services from a provider.

Suicide Attempt-

Physical attempt by a client to cause his or her own death

Baker Act –

Involuntary admission of a client for involuntary examination or placement for psychiatric care

Reportable Incident

Non-violent Crime Arrest –

Arrest of a client for a non-violent crime while under the direct care of a provider.

Section 6

Overview of Medication Administration and Behavior Emergency Procedures

65G-7 Rule

- Medication Administration
- Appropriate training and validation required
- Document on the Medication Administration Record

Reactive Strategies

Rule 65G-8 of the Florida Administrative Code

Reactive strategies are the procedures or physical crisis management techniques of seclusion or manual, mechanical, or chemical restraint utilized for control of behaviors that create an emergency or crisis situation.

Reactive Strategies

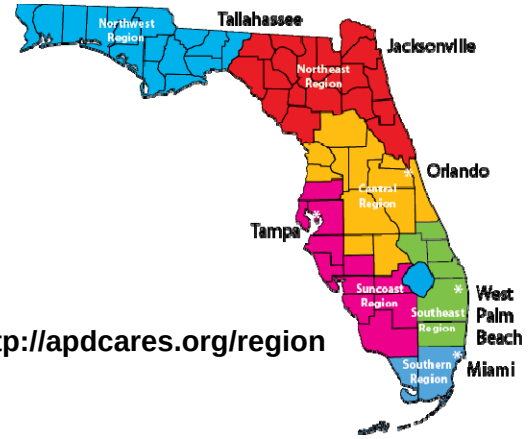
Rule 65G-8 of the Florida Administrative Code

- Protects clients from unnecessary restraint and seclusion
- Requires training
- Prevents the use of reactive strategies when not medically safe and identifies who can authorize them
- Limits or prohibits certain procedures
- Requires documentation and reporting

Section 7

Key Contacts

Regional Offices



http://apdcares.org/region

Contacts

Provider Enrollment
(800) 280-7700-Option 4
(8 a.m. – 5 p.m. ET)

Web Portal Password Reset
(800) 289-7700- Option
(7:30 a.m.- 6 p.m. ET)

http://portal.flmmis.com/flpublic

Certificate of Completion

Congratulations!

You have completed the

Requirements for all Waiver Providers Course

My signature on this certificate acknowledges that I viewed the "Requirements for all Waiver Providers" course.

apdCares
CONNECTING YOU TO THE COMMUNITY

_____ _____

Name **Date**

REQUIREMENTS TO WORK AS Agency for Persons with Disabilities Support Coach.

1. Resume
2. 3 Professional references
3. 2 personal references
4. Must be 18yrs of age.
5. Have High School Diploma or GED.
6. Professional License-Not necessary to work but if you have one, need copy.
7. Have one year of Experience or Training.
8. Levell Background done at County Sherriff for last 5 years for traffic & criminal.
9. Level 2 Background through AHCA
10. Affidavit of good moral character:. must be notarized.
11. Driver's License
12. Social Security Card
13. Auto Registration
14. Auto Proof of Insurance
15. CPR Certificate
16. Boodbourne Pathogens/HIV/AIDS certificate
17. First Aid Certificate
18. Hippa Certificate-you can get one free from: http://myattain.org/workshops2/
19. Zero Tolerance Certificate-done within first 30 days.
20. Health & Safety Certificate-done within first 30 days.
21. Introduction to Developmental Disabilities Certificate-done within first 30 days.

NAME:_____

DATE:_____

By signing this document, you are stating that you have read and understand the duties of the position Personal Support.

SIGNATURE:_____

Personal Supports

Description

Personal supports services provide assistance and training to the recipient in activities of daily living, such as eating, bathing, dressing, personal hygiene, and preparation of meals. When specified in the support plan, this service can also include heavy household chores to make the home safer, such as washing floors, windows and walls; tacking down loose rugs and tiles; or moving heavy items or furniture. Services also include non-medical care, and supervision. This service can provide access to community-based activities that cannot be provided by natural or unpaid community supports and are likely to result in an increased ability to access community resources without paid support.

Personal supports are designed to encourage community integration. Personal supports in supported living are also designated to teach the recipient about home-related responsibilities.

This service can also include respite services to a recipient age 21 years or older living in their family home. Respite services provide relief to the caregiver and is incorporated into the personal support service. The provider, to the extent properly qualified and licensed, assists in maintaining a recipient's own home and property as a clean, sanitary and safe environment.

This service is provided in support of a goal included the support plan or an identified need to support or maintain basic health and safety and is not purely diversional in nature.

Personal Supports, continued

Who Can Receive	Personal supports for individuals in the family home are limited to adults 21 years or older. Personal supports can be provided to recipients age 18 years or older who are in a supported living situation or living in their own home.
Who Can Provide	Providers of personal supports can be a licensed home health or hospice agency, a licensed residential facility, or a solo or agency provider that meets the minimum qualifications in Chapter 1.
Place of Service	Personal supports are provided in the recipient's own home, family home, licensed residential facility if being used as respite, or when or engaged in a community activity. Personal supports can also be provided at the recipient's place of employment. No service can be provided or received in the provider's home, the home of a relative or friend of the provider, a hospital, an ICF/IID or other institutional environment. If renting, the name of the recipient receiving personal supports services must appear on the lease either singularly, with a roommate, or a guarantor. If the recipient has a legal guardian, the legal guardian's name may appear on the lease with the recipient. Personal supports services rendered by a provider or an employee of a provider who is living in a recipient's home must be billed at the daily rate for the service.
Limitations and Exclusions	The recipient's support plan must specifically explain the duties that a personal supports provider will perform for the recipient. Personal supports services cannot be provided during the time a recipient is attending an adult day training program. Assistance is provided on a one-on-one basis to recipients who live in their family homes unless they are engaged in a community-based activity. Community-based activity is provided to recipients living in their family home or in their own homes in groups not to exceed three. If the recipient resides in supported living arrangements and receives both personal supports and supported living coaching then the provider must coordinate their activities to avoid duplication. The personal supports services are separate and are not a replacement for the services performed by a supported living provider. Personal supports provided in supported living must follow plans and strategies developed by the supported living provider as detailed in the support plan, implementation plan, or both.

Personal Supports, continued

Limitations and Exclusions, continued

Personal supports providers are not reimbursed separately for transportation and travel costs. These costs are integral components of the personal supports service and are included in the basic rate. However, in limited circumstances for individuals with extremely challenging behaviors that cause the individual to be a health and safety risk, the personal support provider may accompany the recipient during transportation services to ensure health and safety. These situations must be approved by exception by the APD regional office.

Recipients living in foster or group homes are not eligible to receive personal supports, except:

- To facilitate an overnight visit with family or friends away from the foster or group home.
- When a group home resident recovering from surgery or a major illness does not require the care of a nurse, and the group home operator is unable to provide the personal attention required to ensure the recipient's personal support needs are being met. Under these circumstances, it would be considered reasonable to provide this service to a group home resident only on a time-limited basis. Once the recipient has recovered, the service must be discontinued. The use of personal supports in this situation must be requested by the WSC and approved by the APD regional office, with a copy of the approval maintained in the WSC file and the provider file.
- When a recipient living in a licensed group home is employed and needs personal supports services at the employment site.

The provider or the provider's immediate family must not be the recipient's landlord or have any interest in the ownership of the housing unit.

Reimbursement

There are three reimbursement options for personal supports. The rates must be based on the most cost effective arrangement to meet the recipient's need.

- Quarter hour: Personal supports may be billed for up to 96 quarter-hours per day, if it is the most cost effective rate to meet the recipient's needs.
- Daily: Personal supports needed for more than eight hours per day can be billed at the daily rate if it is the most cost effective rate to meet the recipient's needs.

Personal Supports, continued

Reimbursement, continued

- Combined daily and quarter hours: Up to 6 hours or 24 quarter-hours above the daily rate may be approved to provide additional supports that must be billed by the quarter hour. Personal supports billed by the quarter hour above the daily rate may be approved under the following circumstances:
  - Recipient requires additional supervision due to intense behavioral challenges that make the recipient a danger to themselves or others. In this situation, the recipient must have a behavioral services plan that is implemented by the personal support provider, and the recipient requires visual supervision during all waking hours and intervention as determined by a certified behavioral analyst. The behavioral services plan and its effects on the behavior must be re-viewed by the LRC on a regular schedule as determined appropriate by the LRC.
  - Recipient requires temporary additional supervision and assistance to recover from a medical condition, procedure, or surgery. The additional supports may only be approved on a time limited basis during the recipient's recovery. This must be documented by medical information signed by the recipient's physician.
  - Recipient requires total physical assistance to include lifting and transferring, in at least three of the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene, due to physical, cognitive or behavioral limitations. Also, the recipient must require physical assistance during sleep hours to meet their health and safety needs.

Reimbursement for nursing oversight of services provided by home health agencies and nurse registries, as required by 42 CFR 484.36 and Chapter 59A-8 F.A.C., is not a separate reimbursable service. The cost must be included in the personal supports service.

ABUNDANT LIFE NURSING

EMPLOYMENT APPLICATION

Please Print Clearly and Use Black Ink Only

Name_____
Last First Middle initial

Current address_____
Street address City State Zip code

Home phone_____ Cell phone_____
At this location until

Permanent address_____
Street address City State Zip code

Phone_____ Emergency Phone_____ Email address_____
Best time/day to reach you Relationship

Professional discipline_____

Social Security number_____ Driver's License state/number_____

How did you learn about ALN?_____ Date available_____

Referred by:_____ Email address_____

Education	Name and Location of School	Date Graduated	Degree/Credentials Earned
Basic Education			
Graduate Education			
Certificate Program/Other			

PROFESSIONAL CREDENTIALS

EXPERIENCE / SPECIALTY AREAS (most current first) 1.

1. _____ Years Experience _____ 3._____ Years Experience _____

2. _____ Years Experience_____ 4. _____ Years Experience _____

3. PLEASE INDICATE WHICH OF THE FOLLOWING RESUSCITATION CREDENTIALS YOU CURRENTLY HOLD

(Please attach appropriate copies. Use paper clip only. Do not staple form.

BCLS Expiration Date_____ PALS Expiration Date_____

ACLS Expiration Date_____ NRP Expiration Date_____

Other _____

PLEASE INDICATE ANY NATIONAL CERTIFICATIONS YOU PRESENTLY HOLD (eg. CCRN, CNOR)

(Please attach appropriate copies. Use paper clip only. Do not staple form)

1. _____ Expiration Date_____ 3._____ Expiration Date_____

2. _____ Expiration Date_____ 4._____ Expiration Date_____

Continuing Education:

1._____ 3. _____

2._____ 4. _____

Memberships in Professional Organizations_____

List any additional education, skills, experience, and/or resume/CV or other relevant qualifications on a separate sheet and attach to application.

LICENSURE (Submit all licenses currently held, as well as state of original license if not currently held. Include photocopies of all licenses held)

State:_____(Original) State:_____ State:_____ State:_____

Expiration Date:_____ Expiration Date:_____ Expiration Date:_____ Expiration Date:_____

EMPLOYMENT PROFILE

Applicant's name: ____________________

Please indicate all of your employment for the past ten (10) years, beginning with your most recent employer.
Are you employed now? ☐ Yes ☐ No If so, may we contact your present employer? ☐ Yes ☐ No

Facility / Employer____________________ Dept.____________________
Street address____________________ City__________ State__________ Zip Code__________
Dates employed: From__________ To__________ Reason for leaving__________
____________________ Position held____________________ Specialty__________
____________________ Supervisor's name and title____________________
____________________ Phone__________ Others supervisor?____________________
____________________ Phone__________ Travel assignment? ☐ Yes ☐ No

Facility / Employer____________________ Dept.____________________
Street address____________________ City__________ State__________ Zip Code__________
Dates employed: From__________ To__________ Reason for leaving__________
____________________ Position held____________________ Specialty__________
____________________ Supervisor's name and title____________________
____________________ Phone__________ Others supervisor?____________________
____________________ Phone__________ Travel assignment? ☐ Yes ☐ No

Facility / Employer____________________ Dept.____________________
Street address____________________ City__________ State__________ Zip Code__________
Dates employed: From__________ To__________ Reason for leaving__________
____________________ Position held____________________ Specialty__________
____________________ Supervisor's name and title____________________
____________________ Phone__________ Others supervisor?____________________
____________________ Phone__________ Travel assignment? ☐ Yes ☐ No

Facility / Employer____________________ Dept.____________________
Street address____________________ City__________ State__________ Zip Code__________
Dates employed: From__________ To__________ Reason for leaving____________________ Position held____________________ Specialty____________________
Supervisor's name and title____________________ Phone____________________
Others supervisor?____________________ Phone____________________
Travel assignment? ☐ Yes ☐ No Local staffing agency? ☐ Yes ☐ No

Other names under which you have been employed____________________

Please document reasons for periods you were not employed.

The information provided in the application for employment/subcontractor program is true, correct and complete. I acknowledge that any misstatement or omission of fact on the application may result in my disqualification from employment/subcontract.
I authorize ALN to release this application and reference information to ALN Client institutions, only after receiving my express written or verbal consent for each assignment opportunity. I understand that giving ALN permission to submit my application for assignment opportunities, I am also agreeing to any criminal background search that may be required by certain states or Client institutions.

Signature____________________ Date__________

REFERENCE CHECK FORM

Applicant Name: _____ Position: _____

Personal references checked:

Name: _____ Relationship: _____
Address : _____
Telephone: _____ Date contacted: _____ Method of contact: _____
Notes:_____
_____

Name: _____ Relationship: _____
Address : _____
Telephone: _____ Date contacted: _____ Method of contact: _____
Notes:_____
_____

Name: _____ Relationship: _____
Address : _____
Telephone: _____ Date contacted: _____ Method of contact: _____
Notes:_____
_____

Employment references checked:

Name: _____ Employer: _____
Relationship: _____ Dates of employment: _____Pay: _____
Address : _____
Telephone: _____ Date contacted: _____ Method of contact: _____
Would you rehire? _____ Reason for termination: _____
Notes:_____
_____

Name: _____ Employer: _____
Relationship: _____ Dates of employment: _____Pay: _____
Address : _____
Telephone: _____ Date contacted: _____ Method of contact: _____
Would you rehire? _____ Reason for termination: _____
Notes:_____
_____

Name: _____ Employer: _____
Relationship: _____ Dates of employment: _____Pay: _____
Address : _____
Telephone: _____ Date contacted: _____ Method of contact: _____
Would you rehire? _____ Reason for termination: _____
Notes:_____
_____

Records checked:

- ☐ School records (date requested: _____) Notes: _____
- ☐ Criminal records (date requested: _____) Notes: _____
- ☐ Driving records (date requested: _____) Notes: _____
- ☐ Credit records (date requested: _____) Notes: _____

agency for persons with disabilities
State of Florida

AFFIDAVIT OF GOOD MORAL CHARACTER

State of Florida County of _____

Before me this day personally appeared _____ who, being duly sworn, says:

I am an applicant for employment as a direct service provider or other individual screened pursuant to Chapter 435, Florida Statutes, and Section 393.0655, Florida Statutes, or I am currently employed as a direct service provider with:

_____

By signing this form, I swear and affirm that I have not been found guilty of or entered a plea of guilty or nolo contendere (no contest) to, regardless of the adjudication, any of the following charges under the provisions of the Florida Statutes or under any similar statute of another jurisdiction. I attest that I have not been arrested for any of the following offenses and am currently awaiting disposition. I also attest that I have not been adjudicated delinquent for any of the following offenses, regardless of whether the records have been sealed or expunged.

I understand that I must acknowledge the existence of any criminal records relating to the following list of offenses. I understand that I am also obligated to notify my employer of any possible disqualifying offenses that may occur while employed in a position subject to background screening under Chapter 435, Florida Statutes. I further understand that the list stated below is subject to change and may include offenses that were not previously included.

NOTE: *The following list of offenses has been updated August 1, 2010, and includes offenses specifically applicable to direct service providers under Chapter 393, Florida Statutes.*

Offenses Relating to:

Sections:	393.0674	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
	393.135	Sexual misconduct with certain developmentally disabled clients or threats and/or coercion relating to reports or testimony of sexual misconduct
	394.4593	Sexual misconduct with certain mental Health patients
	409.920	Medicaid provider fraud
	409.9201	Medicaid fraud
	415.111	The filing or disclosure of information from reports of adult abuse, neglect, or exploitation of aged persons or disabled adults
	741.30	Criminal acts that constitute domestic violence as defined in section 741.28, Florida Statutes
	782.04	Murder
	782.07	Manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child
	782.071	Vehicular homicide
	782.09	Killing of an unborn child by injury to the mother
Chapter:	784	Assault, battery, and culpable negligence, if the offense was a felony.
Sections:	784.011	Assault, if the victim of offense was a minor
	784.03	Battery, if the victim of offense was a minor
	787.01	Kidnapping
	787.02	False imprisonment
	787.025	Luring or enticing a child for an unlawful purpose
	787.04(2)	Taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings
	787.04(3)	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

	790.115(1)	Exhibiting firearms or weapons within 1,000 feet of a school
	790.115(2)(b)	Possessing an electric weapon or device, destructive device, or other weapon on school property
	794.011	Sexual battery
	794.041	Former offenses for prohibited acts of persons in familial or custodial authority
	794.05	Unlawful sexual activity with certain minors
Chapter:	796	Prostitution
Section:	798.02	Lewd and lascivious behavior
Chapter:	800	Lewdness and indecent exposure
Section:	806.01	Arson
Sections:	810.02	Burglary
	810.14	Voyeurism, if the offense is a felony
	810.145	Video voyeurism, if the offense is a felony
Chapter:	812	Felony offenses for theft and/or robbery and related crimes
Sections:	817.034	Fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems
	817.234	False and fraudulent insurance claims
	817.505	Patient brokering
	817.563	Felony offenses for the fraudulent sale of controlled substances
	817.568	Criminal use of personal identification information
	817.60	Obtaining a credit card through fraudulent means
	817.61	Felony offenses for the fraudulent use of credit cards
	825.102	Abuse, aggravated abuse, or neglect of an elderly person or disabled adult
	825.1025	Lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult
	825.103	Felony offenses for the exploitation of an elderly person or disabled adult
	826.04	Incest
	827.03	Child abuse, aggravated child abuse, or neglect of a child
	827.04	Contributing to the delinquency or dependency of a child
	827.05	Negligent treatment of children
	827.071	Sexual performance by a child
	831.01	Forgery
	831.02	Uttering forged instruments
	831.07	Forging bank bills, checks, drafts, or promissory notes
	831.09	Uttering forged bank bills, checks, drafts, or promissory notes
	843.01	Resisting arrest with violence
	843.025	Depriving a law enforcement, correctional, or correctional probation officer means of protection or communication
	843.12	Aiding in an escape
	843.13	Aiding in the escape of juvenile inmates in correctional institution
Chapter:	847	Obscene literature
Section:	874.05(1)	Encouraging or recruiting another to join a criminal gang
Chapter:	893	Drug abuse prevention and control if the offense was a felony or if any other person involved in the offense was a minor
Sections:	916.1075	Sexual misconduct with certain forensic clients and reporting requirements for such sexual misconduct
	944.35(3)	Inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm
	944.40	Escape
	944.46	Harboring, concealing, or aiding an escaped prisoner
	944.47	Introduction of contraband into a state correctional facility
	985.701	Sexual misconduct in juvenile justice programs
	985.711	Contraband introduced into detention facilities

ONE OF THE FOLLOWING STATEMENTS MUST BE SIGNED:

Under the penalty of perjury, which is a first degree misdemeanor, punishable by a definite term of imprisonment, not exceeding one year and/or a fine not exceeding $1,000 pursuant to ss.837.012, or 775.082, or 775.083, Florida Statutes, I attest that I have read the foregoing, and I am eligible to meet the standards of good character for this caretaker position. This means that I have not been found guilty of or entered a plea of guilty or nolo contendere (no contest) to, regardless of adjudication, any of the offenses listed above or any similar statute of another jurisdiction. I attest that I have not been arrested for any of the above offenses and I am not currently awaiting disposition of any of the above offenses. I also attest that I have not been adjudicated delinquent for any of the above offenses, regardless of whether those records have been sealed or expunged.

_____
Signature of Affiant

OR

To the best of my knowledge and belief, my record may contain one or more of the foregoing disqualifying acts or offenses.

_____
Signature of Affiant

OR

I swear or affirm that I am a licensed physician, licensed nurse, or other professional licensed and regulated by the Department of Health. I will be providing services that are 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

Sworn to and subscribed before me this _____ day of _____, _____

_____ _____
My commission expires NOTARY PUBLIC, STATE OF FLORIDA

My signature, as a Notary Public, verifies the affiant's identification has been validated by

_____

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

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

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

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

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

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
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.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		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				

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

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

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member 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 FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

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

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 Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 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 on page 3.

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

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

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?* on page 2 for further information.

Employee Direct Deposit Authorization

Instructions

Employee: Fill out and return to your employer.

Employer: Save for your files only.

This document must be signed by employees requesting automatic deposit of paychecks and retained on file by the employer. Employees must attach a voided check for each of their accounts to help verify their account numbers and bank routing numbers.

Account 1

Account 1 type: ◯ Checking ◯ Savings

Bank routing number (ABA number): _____

Account number: _____

Percentage or dollar amount to be deposited to this account: _____

Account 2 (remainder to be deposited to this account)

Account 2 type: ◯ Checking ◯ Savings

Bank routing number (ABA number): _____

Account number: _____

attach a voided check for each account here

Authorization (enter your company name in the blank space below) _____

This authorizes _____ (the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries. I agree that the ACH transactions authorized herein shall comply with all applicable U.S. Law. This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Authorized signature: _____ Employee ID #: _____

Print name: _____ Date: _____

TIME SHEETS DUE	BILLING DATE	DATE TO ACCOUNTANT	PAY PERIOD BEGINNING	PAY PERIOD ENDING	PAY DATE	COMMENTS
1/2/2017	1/4/2017	1/11/2017	12/18/2016	12/31/2016	1/13/2017	2017 WEEK 1
1/16/2017	1/18/2017	1/25/2017	1/1/2017	1/14/2017	1/27/2017	2017 WEEK 2
1/30/2017	2/1/2017	2/8/2017	1/15/2017	1/28/2017	2/10/2017	2017 WEEK 3
2/13/2017	2/15/2017	2/22/2017	1/29/2017	2/11/2017	2/24/2017	2017 WEEK 4
2/27/2017	3/1/2017	3/8/2017	2/12/2017	2/25/2017	3/10/2017	2017 WEEK 5
3/13/2017	3/15/2017	3/22/2017	2/26/2017	3/11/2017	3/24/2017	2017 WEEK 6
3/27/2017	3/29/2017	4/5/2017	3/12/2017	3/25/2017	4/7/2017	2017 WEEK 7
4/10/2017	4/12/2017	4/19/2017	3/26/2017	4/8/2017	4/21/2017	2017 WEEK 8
4/24/2017	4/26/2017	5/3/2017	4/9/2017	4/22/2017	5/5/2017	2017 WEEK 9
5/8/2017	5/10/2017	5/17/2017	4/23/2017	5/6/2017	5/19/2017	2017 WEEK 10
5/22/2017	5/24/2017	5/31/2017	5/7/2017	5/20/2017	6/2/2017	2017 WEEK 11
6/5/2017	6/7/2017	6/14/2017	5/21/2017	6/3/2017	6/16/2017	2017 WEEK 12
6/19/2017	6/21/2017	6/28/2017	6/4/2017	6/17/2017	6/30/2017	2017 WEEK 13
7/3/2017	7/5/2017	7/12/2017	6/18/2017	7/1/2017	7/14/2017	2017 WEEK 14
7/17/2017	7/19/2017	7/26/2017	7/2/2017	7/15/2017	7/28/2017	2017 WEEK 15
7/31/2017	8/2/2017	8/9/2017	7/16/2017	7/29/2017	8/11/2017	2017 WEEK 16
8/14/2017	8/16/2017	8/23/2017	7/30/2017	8/12/2017	8/25/2017	2017 WEEK 17
8/28/2017	8/30/2017	9/6/2017	8/13/2017	8/26/2017	9/8/2017	2017 WEEK 18
9/11/2017	9/13/2017	9/20/2017	8/27/2017	9/9/2017	9/22/2017	2017 WEEK 19
9/25/2017	9/27/2017	10/4/2017	9/10/2017	9/23/2017	10/6/2017	2017 WEEK 20
10/9/2017	10/11/2017	10/18/2017	9/24/2017	10/7/2017	10/20/2017	2017 WEEK 21
10/23/2017	10/25/2017	11/1/2017	10/8/2017	10/21/2017	11/3/2017	2017 WEEK 22
11/6/2017	11/8/2017	11/15/2017	10/22/2017	11/4/2017	11/17/2017	2017 WEEK 23
11/20/2017	11/22/2017	11/29/2017	11/5/2017	11/18/2017	12/1/2017	2017 WEEK 24
12/4/2017	12/6/2017	12/13/2017	11/19/2017	12/2/2017	12/15/2017	2017 WEEK 25
12/18/2017	12/20/2017	12/27/2017	12/3/2017	12/16/2017	12/29/2017	2017 WEEK 26
1/1/2018	1/3/2018	1/10/2018	12/17/2017	12/30/2017	1/12/2018	2017 WEEK 27

abundantlifenursing88@yahoo.com

abundantlifenursing.com

2280 W. Old US Hwy 441
Mount Dora, FL 32757
(352) 250-2748 Office
(352) 600-3091 Fax

ABUSE AND NEGLECT POLICY AND PROCEDURE

Abundant Life Nursing and Supportive Services, LLC is responsible for providing services and to detect and report any abuse, neglect, and exploitation of vulnerable adults who, because of their age or disability, may be unable to adequately provide for their own care or protection. In taking action to prevent further abuse, neglect, and exploitation, Abundant Life Nursing and Supportive Services, LLC must place the fewest possible restrictions on personal liberty and exercise of constitutional rights. Abundant Life Nursing and Supportive Services, LLC actions must be consistent with due process and protection from abuse, neglect, and exploitation. Law enforcement takes the lead in all criminal investigations and prosecution.

MANDATORY REPORTERS

Although every person has a responsibility to report suspected abuse or neglect, some occupations are specified in Florida law as required to do so. Abundant Life Nursing and Supportive Services, LLC and any of our employees or subcontractors are considered "professionally mandatory reporters". A professionally mandatory reporter of abuse/neglect is required by Florida Statute to provide his or her name to the Abuse Hotline Counselor when reporting. A professionally mandatory reporter's name is entered into the record of the report, but is held confidential (§ 39.202, F.S. and 415.107, F.S.)

HOW TO MAKE A REPORT

Everyone, including professionally mandatory reporters, should contact the Florida Abuse Hotline when they know or have reasonable cause to suspect that a child or a vulnerable adult has been abused, abandoned, neglected, or exploited. The Florida Abuse Hotline Counselor will determine if the information provided meets legal requirements to accept a report for investigation.

By Telephone	1-800-96ABUSE (1-800-962-2873)
By Fax	1-800-914-0004
By TDD	1-800-453-5145
Web Reporting	http://reportabuse.dcf.state.fl.us

Employee:_____ Date:_____

ABUSE AND NEGLECT
POLICY AND PROCEDURE DEFINITIONS

Abuse	The willful infliction by a caregiver of physical pain or injury, or the willful deprivation of services necessary to the physical safety of an individual.
Psychological Abuse	Acts that inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade, demean or otherwise negatively impact the mental health or safety of an individual.
Verbal Abuse	The use of offensive and/or intimidating language that can provoke or upset an individual.
Neglect	The failure by a caregiver, through action or inaction, to provide an individual with the services necessary to maintain his or her physical and mental health and safety, including incidents of inappropriate or unwanted individual to individual sexual contact. Neglect also includes the failure of a caregiver to respond to incidents of inappropriate or unwanted sexual contact between individuals who receive services from the department. Neglect is also a situation in which an individual lives alone and is not able to provide for him/herself the services, which are necessary to maintain his physical, mental health or safety.
Financial Exploitation	The theft or misappropriation of property and/or monetary resources, which are intended to be used for or by an individual.
Sexual Abuse	Any sexual contact or encouragement of sexual activity between a family member, paid staff or a volunteer and an individual, regardless of consent.

Ten Performance Standards For ALL Staff

1. Speak To All People Politely
2. Include People In Conversation
3. Use Positive Communication
4. Explain In Ways That Can Be Understood
5. Encourage People To Think For Themselves
6. Teach People To Do As Much As Possible
7. Include People In Making Decisions
8. Respect Differences And People's Desires
9. Consider A Person's Feelings and Concerns
10. Listen To Other People's Point Of View

Employee:_____ Date:_____

abundantlifenursing88@yahoo.com

abundantlifenursing.com

2280 W. Old US Hwy 441
Mount Dora, FL 32757
(352) 250-2748 Office
(352) 600-3091 Fax

I _____ acknowledge that I have received and read

General Guidelines Booklet for Abundant Life Nursing and Supportive Services, LLC. I will adhere

To all policies outline in this booklet.

_____ _____

Signature

Abundant Life and Supportive Services LLC

General

Abundant Life Nursing and Supportive Services LLC. practices will be an accurate representation of data within the following written policies and procedures. Any revisions to these policies and procedures will be made within 30-days of notification or indication that modifications are deemed necessary because they differ from the policies written. The following policies and procedures shall remain in effect until revised as described above and shall apply to Residential Habilitation, Supported Living Coaching, Supported Employment, Skilled Nursing, Residential Nursing and all other services provided by Abundant Life Nursing and Supportive Services, LLC.

Persons-Centered-Approach

- **Policy:** Services delivered and/or provided to assess, with a consumer, the outcomes the consumer considers most important and to plan with the consumer how to achieve these outcomes. The goals set forth in the consumer's support plan will be used to establish measurable goals and outcomes. The goals of the consumer will become the basis for the services provided and will be the benchmark against which to judge/track progress. Consumer implementation plans will be initiated and formalized by this agency with 30 days service provision and receipt of the support plan from the Support Coordinator.

- **Purpose:** To create a program focused the on consumer's goals, natural supports and desired outcomes.
- **Procedure:** The following will be adhered to for each consumer on an individual basis:
    - Abundant Life and Supportive Services will become familiar with the consumer and important persons in the consumer's life by completing the Relationship Support Plan document meeting within 10 days of the support plan meeting. Director (and staff) will review gathered information with consumer and agree on interventions and course of action.

    - Information will be gathered by Abundant Life Nursing and Supportive Services LLC from the consumer and significant people in the consumer's life to determine the presence or absence of personal outcomes.

    - Supports to achieve the consumer's outcome will be identifies in the process.

    - Abundant Life Nursing and Supportive Services LLC will use reviews of records, on-site visits, and additional interviews when deemed necessary to identify the outcomes, the support being used or needed to achieve those outcomes, and determine if an outcome has, or is, being met.

    - Abundant Life Nursing and Supportive Services LLC will assist the consumer, as well as other providers, to meet the major expectations that the consumer has for his/her life (or personal goals).

    - Expectations of the consumer for the services and supports received are defined by these outcomes.

- The Support Coordinator will compile, report, and plan from the information gathered and given to him/her in the personal outcome process.

- Abundant Life Nursing and Supportive Services LLC staff will complete the Personal Outcomes Training as provided by Developmental Services in order to gain knowledge of the Personal Outcome process and establish person-centered approach to service deliver.

- The results of the Personal Outcome Measure will determine the services, supports needed and initiation techniques.

Outcomes or goals that are reflected in the consumer's Support Plan will become the basis for the services provided.

- An implementation plan will be developed by Abundant Life Nursing and Supportive Services LLC within 30 days of receiving the Support Plan and service authorizations.

- The measureable goals and outcomes will become the benchmark by which to judge/track progress.

- Implementation Plans (IP) will be reviewed on at least a quarterly basis to ensure appropriate levels of service are being given.

- A file will be maintained on each consumer in compliance with licensing standards of Developmental Services, the State of Florida, and the Medicaid Waiver Services Agreement, including the Core Assurances, and the Developmental Services Home and Community-Based Services Waiver Services Directory.

- The file or record each consumer will contain at a minimum the following:
  - Authorization for services
  - An Annual Support Plan
  - An Individual Implementation Plan
  - Demographic Information
  - Medical Information
  - Progress/Case Notes, including adequate documentation to support services received and billed
  - An annual progress report that summarizes the consumer's status and skill development in an independent living arrangement.

- The following operating principles will be observed:
  - Preserve and empower consumers/families
  - Provide services in a manner that is safe for the consumer
  - Provide community and home-based waiver services through an array of well-coordinated services
  - Avoid consumer removal from the community

- Work with the consumer/families/other providers to ensure the successful transition and/or placement in an independent living arrangement.

Staffing Availability

Title	Number of Staff
Chief Director of Services (Patricia Allen R.N)	1
Directors of Administrative Services	1
Director of Services	1
Direct Care Workers	4

- The administrator will be on-call and available 24/7 to address issues and emergencies and provide authorization as necessary. The Directors of Administrative Services is Shayla Allen (CNA)
- The Executive Director of Services is Shayla Allen, and will be available 24/7 and whenever the Chief Director of Service is out of town, or otherwise unavailable.
- The direct care worker will be on duty 4 to 12 hours shifts as needed. There will be a total of two or three shifts daily.
- In the event that a staff member calls is not able to perform his/her duties; they are to notify administration immediately. When notified administration staff will either find another staff member to cover the shift or an administrator will cover the shift.

POLICY FOR 24/7 COVERAGE

I, Patricia Allen RN will be available either in persons or via phone on a 24 hour 7 days a week basis. In the event that I am going to be out of the area, I will inform the recipient of my plans and arrange back-up by:

Wandretta L. Dudley, Provider of Love Thy Neighbor

Consumers and their family members will always have contact information for the director and administrative staff.

Abundant Life and Supportive Services LLC

Background Screening

I, Patricia Allen, owner of Abundant Life Nursing and Supportive Services, Inc., will ensure that all staff , have passed a Level Two Background Screening in accordance with Florida Statute 393.0655. The completed Live Scan fingerprinting process at an approved Live Scan provider, the completed Affidavit of Good Morale Character, and local law background screening form must be forwarded to the Agency for Persons with Disabilities Area 13 office within 5 days of hiring. The area office will receive the results of the level two background screening. The fingerprinting and local law background screening process will be completed every 5 years thereafter.

Promotion of Health and Safety for Consumers

- **Policy:** Abundant Life Nursing and Supportive Services, LLC. adopts the following policy to insure the health and safety of consumers. This agency is committed to procuring quality care for its consumers, whether they live with their families or in a residential facility when parents or guardians are unavailable.

- **Procedure:**
    - Abundant Life Nursing and Supportive Services LLC. will encourage and assist in each of the consumer's well-being by aiding in selection of doctors who will be chosen following these criteria.
    - The Consumer's Family physician will be maintained, whenever possible, as long as they accept Medicaid, or private insurance coverage.
    - The Waiver Support Coordinator will be contacted as a referral source for doctors and dentists.
    - The Florida Agency for Persons with Disabilities can assist in finding doctors for consumers with Medicaid coverage.
    - Contact a physician referral service for further assistance, when needed.

- Doctors will be changed if there is due cause, following these criteria:

    - When the doctor no longer will accept Medicaid, Medicare, or private insurance coverage, another doctor will be obtained using the above criteria.
    - If there is concern about a doctor's care for a consumer, the Waiver Support Coordinator is to be notified. Abundant Life Nursing and Supportive Services LLC can personally accompany the consumer to their next visit to assess this concern and the necessity to change doctor.
- The need for a medical specialist will determined by the consumer's primary care physician, as follows:

    - Problems will be reported to the doctor objectively by the appropriate individual who scheduled the appointment.

Medication Administration

- **Policy:** It is the policy of Abundant Life Nursing and Supportive Services LLC. to strictly adhere to Agency for Persons with Disabilities and Developmental Disabilities Med Waiver Policy and Procedure regarding medication administration.

- **Purpose:** To ensure that medication is administered to the correct consumer in the manner it is prescribed.

- **Procedure:**

    - Only Trained Staff will administer medication to any consumer in this agency
    - Wash hands before administering medication.
    - Double check dose and times against the container label and/or the Medication Administration Record (MAR)

    - Confirm that the individual present is the correct individual whom the medication should be given.
    - Check for special instructions such as taking vital signs before administration. If needed.
    - Give water or other liquid, as instructed and after each pill is administered
    - Check and make sure medication has been swallowed before leaving the individual,
    - In the event medication is not fully ingested or dose is given more than hour after scheduled to be given, report to attending physician for further instruction. Record approval on MAR.
    - Record all medication administration on the MAR immediately
    - If needed, observe the individual following the administration to ensure effectiveness of medication or to note side effects and any adverse reaction.
    - The client's physician will prescribe all administered medications and treatment to be implemented.
    - All prescription medication will be kept with its original dated label, with legible information, including the prescription number, directions for use, client's and physicians name, the address and phone number of the issuing pharmacy and the expiration date.
    - Self-administered medication: A client who is deemed capable of handling his/her own medication will be encouraged to do so. Medication will remain in a locked cabinet and

will be available as ordered. Client will administer his/her own medication under direct staff supervision.

- A daily record of all medication including self-administered medication will be kept.
- All medications will be kept in a locked cabinet.
- The following ix (6) Rules of medication administration will be adhered every time medication is administered:
    - Right Client
    - Right Medication
    - Right Route
    - Right Dose
    - Right Time
    - Right Documentation
- Clients on psychotropic drugs will be closely monitored for side effects of specific drugs and drug levels as ordered by the psychiatrist.
- Clients taking multiple psychiatric medication will have a comprehensive psychiatric review completed on a quarterly basis.
- Any error in medication administration such as administering the wrong dose to the wrong client, omitting a dose, administering the wrong dose will be immediately documented and reported to the physician, the supervisor and District Medical case Manager. The client will be closely monitored and any observable change in his/her behavior should be immediately reported to their physician.
- A list of side effects or adverse effects and possible drug interactions for each medication administered will be kept in the client's Medication Administration Record (MAR)
- Medications that have been discontinued by the client's physician will be flushed down the drain by the supervisor.

Smooth Transition Between Providers and Support Services

- **Purpose:** To ensure that transition/discharges in services are consistent with the consumer's needs and are in the least restrictive and most appropriate level of care. To ensure that the transition summary or discharge summary is linked with assessments. Begins at the time of admission, and is reflective of individual needs and the ability of the programs to provide the specified services.

- **Policy:** All transitions in a consumer's services will be consistent with the individual's needs and will be in the least restrictive and most appropriate level of care. Documentation of the assessment and coordination of services will be placed in the consumer's record on a timely basis.

- **Procedure:** Prior to any transition in a consumer's services, Abundant Life Nursing and Supportive Services LLC. will perform the following activities:

    - Assess the consumer's needs for continued services by:
        - The consumer and family regarding further needs.
        - Obtaining relevant information from the referral source.
        - If the consumer is no longer appropriate for continued services, the focus will become a smooth transition in service, which will be coordinated by Abundant Life Nursing and Supportive Services LLC.
        - Staffing the client with the Support Coordinator and regarding the need for services, discharge, continued care at the current level, and follow-up activities.

    - The above listed activated will be clearly and concisely documented in the client record in the progress note section.

If the consumer is no longer appropriate for services, the focus will become a smooth transition in services, which will be coordinated by Abundant Life Nursing and Supportive Services LLC

Based upon the finding of the assessment and current care, Abundant Life Nursing and Supportive Services will begin the transition of care by:

- Reviewing the consumer's file/records to determine if a valid release of information exists to allow the disclosure of information
- Abundant Life Nursing and Supportive Services will complete a valid release of information before any confidential material is released.
- Developing a final discharge plan with the consumer, family referring worker, or other involved professionals.
- Contacting the appropriate referral source for follow-up or discharge planning purposes
- Forwarding the appropriate information already contained in record
- Communicating with the client, family, and/or referral source the final discharge/transition plans.

The above listed activities will be clearly and concisely document in client's record.

- Upon the transition/discharge of the consumer, the Care Provider will complete the procedure by completing a discharge summary by no later than 30 days which contains the following information:

- A note Heading that clearly identifies the note as a "Discharge Summary"
- The closure/discharge date
- The status (terminated, referred to another agency, relocated, or other reason for discharge)
- Summary including explanation, reason for termination, services rendered, and results
- Signature of Care Provider who completed the summary, and
- The date the discharge summary was actually written/documented

Abundant Life and Supportive Services LLC

Provider Training

Purpose: To determine the nature and variety of training topics which Abundant Life Nursing and Supportive Services LLC staff will obtain

Policy: Abundant Life Nursing and Supportive Services LLC. staff will obtain training that is directly related to the duties of Care Providers for the services being provided.

Procedure: This agency will be trained on all processes and procedures

1. The following training will be obtained every 2 years or as mandated by the Department:

- CPR
- APD training to cover Medicaid /Waiver standards and Policies
- Other education or training requirements by the State of Florida
- HIV/AIDS information relating to the transmission and prevention od infection and educational intervention strategies.
- Medication administration (Policy Directive 01-01)
- Significant event reporting
- Development of Implementation Plan
- Other training for "team" building, organization, and/or communication.
- The agency will ensure that they receive specific training required to successfully serve each individual, including the following:
    - Emphasis on individual choice and rights;
    - The responsibilities and procedures for maintaining the health, safety, and well-being of individuals served.
- Recognition of abuse and neglect as well as district/region and Abundant Life Nursing and Supportive Services LLC. reporting procedures
- Training in the development and implementation of the requires documentation for each service rendered;
- Use of personal outcomes to establish a person-centered approach to service delivery
- Training certificated, class outline/agenda and/or notes will be places in the personnel file
- All care providers will obtain at least 12 hours of training per year.

Abundant Life and Supportive Services LLC

Grievance-Appeal Procedure

Policy: Abundant Life Nursing and Supportive Services, LLC. Withholds a vested interest in full protecting the rights and dignity of the consumers it serves. Abundant Life Nursing and Supportive Services, LLC is dedicated to respecting the rights of those serves and adhering to the following procedures in regards to consumer grievances.

Procedures:

- It is the policy of this agency that all persons are treated with respect and in fair manner at all times.
- Abundant Life Nursing and Supportive Services LLC places great importance in creating and maintaining harmonious relationships among all care providers.
- Abundant Life Nursing and Supportive Services LLC continuing objective is to make each person as fully satisfied as possible. However, sometimes in relationships, misunderstandings or difficulties may arise. This agency has established a procedure whereby problems may be known and resolved. The objective in improving the relationships are as follows:
    - Recognized the individuality and dignity of each consumer
    - Establish an atmosphere of mutual respect and understanding between care providers and consumers
    - Resolve misunderstandings in a fair, consistent, and impartial manner for the benefit of the agency and consumers
    - The following procedures has been established to assist in taking immediate steps when problems. Misunderstandings, and/or difficulties arise.

STEP 1: Discuss the problem over with the care provider as soon as possible so that the problem may be resolved quickly. It is important to both the consumer and the care prober that problems and complaints are settles and the only way to accomplish this is to discuss problems fully and frankly with the care provider. Generally most problems can be settles by thorough discussion between the consumer and care provider.

STEP 2: If the problem is not resolved within 3 days or is you do not feel that the care provider has given you, then you may bring matter to the attention of the Support Coordinators. They will discuss the problem with you and the care provider. All facts will be critically re-examined and re-evaluated in an effort to settle the problem within an additional week.

STEP3: If you feel that you have not yet received an answer from your care provider after completing step 2, or if you feel that you did not get a fair solution to your problem, then prepare a statement explaining your problem and request assistance from your Support Coordinator. Your Support Coordinator will schedule a meeting with you and

your care provider within one (1) week of receiving a written statement. Recommendations and possible solutions will be discussed and documented at the meeting in order to reach an equitable solution.

STEP 4: If, after this, you feel that you have not received a fair and equitable answer, then feel free to request a meeting with the Agency for Persons with Disability Developmental Services Representative (APD/DS) The APD/DS Representative will read and review all pertinent information on the problem and will review the problem with the individuals who have been involved up to this point in order to critically evaluate and to make a fair decision. The decision made by the APD/DS Representative will be final.

You may be assured that throughout this grievance procedures, you plaint will be treated in absolute confidence and that it will be given careful consideration. If you feel that the source of your problem is your care provider, you may feel free to eliminate STEP 1 of the grievance procedure. Proceed an contact the Waiver Support Coordinator directly to discuss the problem. In most cases, however, your first step should be with you care provider.

We recognize that being human, mistakes may be made in spite of your best efforts. It is out policy to try to correct such mistakes as quickly as possible when they occur. The only way this can be done is for you to make

your problem and/or complaint known. No care provider is too busy to head problems/complaints from anyone. If you follow the steps outlined here, no one may criticize or discriminate against you for raising a grievance through the grievance procedure, you should report this to be the Program Director. This procedure is established with the hope that is will be freely used and no consumer should fear he/she would be penalized for using this Grievance procedure.

Self-Assessment Procedure

Policy: It is the policy of Abundant Life Nursing and Supportive Services LLC. to provide quality services to each consumer, however, each service should be evaluated to determine the quality of services delivered and that person-centered processes are used to assist individuals in the achievement of personal outcomes, especially with regard to personal goals, choices, social inclusions, relationships, rights, dignity and respect, health, environment, security, and satisfaction. The use of an annual self-assessment is a meaningful way to identify needed improvements and to expand the quality and effectiveness of services and to ensure that Abundant Life Nursing and Supportive Services LLC. is complaint with requirements identified in the Core Assurances and the Developmental Services Home and Community-based Services Waiver Services Directory. This assessment is used to identify the extent to which Abundant Life Nursing and Supportive Services LLC policies, procedures and practices are consistent with the stated objectives in the Medical Waiver Service Agreement.

Procedure:

- An annual assessment will be done randomly on at least one case, following the annual monitoring by the Department. This annual Self-Assessment shall include, at a minimum, the following:
    - Record Review
    - Interview at least one consumer to determine the extent to which Abundant Life Nursing and Supportive Services LLC. actions supported the achievement of personal goals identified by individual receiving services.
    - Individual satisfaction survey or quality of service survey (including the follow-up/response form)

- Satisfaction Surveys/Quality of Services Surveys will:
    - Be completed annually for each consumer, the referring agency, or support coordinator, or other non-supported living staff/providers, and/or family of the consumer (when applicable)
    - Reviewed by Abundant Life Nursing and Supportive Services LLC. to determine the satisfaction with services provided. Modification/changes will be made in order to improve services and please the consumer, (Surveys and/or results can be distributed to the referring agency, support coordinator as becomes necessary)

- Corrections/improvements/enrichments shall be made with the consumer's consent and filed in the consumer's central file maintained by Abundant Life Nursing and Supportive Services LLC.

- A Quality Improvement Plan will be developed addressing the areas of improvement that were identified during the annual self-assessment and the satisfaction surveys. The quality improvement will forwarded to the department within thirty (30) days of receiving the annual report for review and approval.

Abundant Life and Supportive Services LLC

Maintenance of Confidentiality and Storage of Records in a Secure Manner

Purpose: Prevent breaks in consumer confidentiality; protect private information and hinder criminal events that could occur as a result of incorrectly stored patient information.

Process: To maintain consumer information safety, all staff will receive HIPPA training upon accepting employment. Staff will be mandated to retrain in HIPPA standards annually and utilize teachings in their daily activity.

Procedure: Staff is never allowed to divulge person information to unauthorized persons. Family members, friends, neighbors, etc. are all considered "unauthorized persons" unless consumer/guardian dictates otherwise. Staff should never engage in discussion of consumer information in common areas where information can become compromised. If there is any issue involving incorrect release of person information, a supervisor or Patricia Allen (owner) is to be contacted immediately. Disciplinary action will occur immediately if one of these standards is not upheld.

In order to maintain an environment where personal information is safe; all staff will be background screened in accordance to APD standards. All staff will sign a confidentiality agreement that binds them to above described principles and HIPPA standards. Agency will keep all records in a secured/locked area at all times. Files that are stored on the computer will be protected by Norton antivirus/ advanced security suite. The agency will determine which staff has access to protected information. Documents must not be left in areas where members of general population aggregate. Records cannot be transferred from locked area without management approval. Any personal information that needs to be discarded will be shredded immediately.

Release of information is not allowed by direct care staff unless given permission by supervisor. When protected health information is solicited by an outsider or unauthorized person, staff is to contact a supervisor immediately for further instruction. Staff is never to give any information to media/press.

Storage- all records are stored in an area that is at no risk of damage from pests, vermin or any other threat. Records will be stored in internal locations where they are easily accessed when needed. Records will be kept on file for 7 years and will be shredded after that timespan is expired.

agency for persons with disabilities
State of Florida

Facility: _____
Date: _____

AREA THIRTEEN CHECKLIST FOR PERSONNEL FILES

Monitor (s): _____

Employees Names ** Need Expiration Dates

Check List is to be done for each employee that has worked for the past year in the facility/ GH & FH										
1. Date of hire **										
2. Experience Related to Job/ education										
3. 3 Character References										
4. 2 Employer References										
5. Position Description										
6. Employment History										
7. Affidavit of Good Moral Character										
8. Fingerprint, FBI, FDLE ** Date of Fingerprinting										
9. 5-year Background Screening –if applicable		N/A		N/A		N/A		N/A		N/A
10. Local Law Verification										
11. Copy SS Card										
12 Valid Driver's License ** Date Expire										
13. First Aid * Date Expire										
14. CPR ** Date Expire										
15. Blood born pathogens ** Date Expire										
16. Choice & Rights										
17. Emergency Procedure										
18. Behavior management (if CBA assigned)										
19. Confidentiality/HIPPA										
20. Reactive Strategies										
21. Fire Safety										
22. Medication 8 hr.										
23. Med. Validation **										
24. POM/Person Centered										
25. Health & Safety										
Direct Core Comp. Base										
3. Zero Tolerance * Date Expire-3 years after training Date										