Staff Files Checklist for 245D Compliance

- ☐ Employee Job Application
- ☐ Copy of ID/Social (optional)
- ☐ Background Clearance Letter
- ☐ Acknowledgment of Job Duties (Signed by staff)
- ☐ Policy Receipt & Signature page (for staff)
- ☐ Staff Orientation Training Record
- ☐ Individual Specific Training Record
- ☐ Staff (ANNUAL) Training Record
- ☐ Employee Job performance Evaluation

AHHC
American Home Health Care

Interview questions:

Today Date: Middle Initial

Name: First Middle Last

Birthday: SS# Male ☐ Female ☐

Document Title: MN DRIVER'S LICENSE

Issuing: Authority STATE OF MINNESOTA

ID number: Expiration Date:

Social Security Card issuing Authority: Social Securety Department

Single ☐ Married ☐ Dependent #: Tax Exempt or N/A:

Are you a citizen? Yes ☐ Are you lawful permanent resident: yes ☑ No

White: ☐ Asian: ☐ Black: ☑ Hispanic/Latino: ☐ other: please completed page 14

Non-veteran: Yes ☑ No ☐ not respond

Disabled: Yes ☐ No ☑ not respond

Address:

Apt#

Street city State Zip County

Email: Phone:

Are you legally entitled to work in the United States? Yes ☑ No ☐

Are you at least 18 years of age? Yes ☑ No ☐

Have you ever been convicted of a crime other than minor traffic violation? Yes ☐ No ☑

New Hire: ☑ Rehire: ☐

Individual pca training date passed: Certificate number:

If previously used for MCO only claims, has this individual maintained continuous employment with your agency? Yes ☐ No ☑

Group Affiliation Information: You have the option to affiliate/enroll the individual PCA named above, if 18 years or older, with other agencies you own without completing another application and agreement. Do you want to affiliate the above named individual PCA with any other agency(ies) you own? Yes ☐ No ☑

Have you passed Competency Testing? Yes ☑ No ☐

Do you have the following:

Driver License: Yes ☑ No ☐ Car: Yes ☑ No ☐ Certificate nay kind: Yes ☑ No ☐

Have you applied for this company before: Yes ☐ No ☑

AHHC
American Home Health Care
www.ahealthcarehome.com
2647 Bloomington Ave Ste U2A Minneapolis, MN 55407
Phone: 763-334-6957 Fax: 763-334-6958
Email: info@ahealthcarehome.com

MN Department of Human Services Background Study Information Form

Agency: American Home Health Care
2716 Portland Ave S
Minneapolis, MN 55407
Agency ID: **99237 and 1096117**

1096117 Home Maker/ Respite **99237 PCA Choice**

Please print legibly. Information provided on this form must match identically to the information on your form of ID (Driver's License, Government Issued ID, Passport or other acceptable document). Please contact American Home Health Care for questions on this requirement.

****ENCLOSE A PHOTOCOPY OF YOUR FORM OF ID WITH THIS FROM. SEE ATTACHED "ACCEPTABLE FORMS OF ID FOR DHS BACKGROUND"**

Minnesota Department of Human Services, Minnesota Bureau of Criminal Apprehension, and the Federal Bureau of Investigation require American Home Health Care to collect this information in order for DHS to conduct a fingerprint based criminal record search.

Personal Data

First Name	Middle Name	Check here if you do not have a middle name ☐	Last Name
Date of Birth (MM/DD/YYYY)	Gender: Male☐ Female☐		Social Security Number*
Phone Number	Email Address		
Race (optional) White☐ Asian☐ Black☑ Hispanic/Latino☐	Eye color		Hair color
Height	Weight		Place of Birth (State) or Country
Preferred contact method for further steps of the background study ☑Email ☐Phone ☐Mail			

*Social Security number is not required to initiate a background study, but is necessary for the background study to be transferrable. Should you wish to work in multiple programs and have your background transferrable, this information is required.)

Other names known by (Maiden names, married names, nicknames, etc.)

First Name	Middle Name	Last Name
First Name	Middle Name	Last Name
First Name	Middle Name	Last Name

Form of Identification Information

Document Type (Driver's License, Government Issued ID, Passport etc.)	Issuing State/Authority
MN DRIVER'S LICENSE	STATE OF MINNESOTA
Document Number	Expiration Date

Permanent Address

Address		
City	State	Zip
Date of Residence: FROM _____ /_____ /_____ TO Current		

Mailing Address ☑ Same as Permanent Address

Address		
City	State	Zip

Previous Out-of-State Addresses within the last 5 years ☐ I have not lived out-of-state within the last 5 years

Address		
City	State	Zip
Dates of Residence: FROM_____(year) TO _____(year)		

Address		
City	State	Zip
Dates of Residence: FROM _____ (year) TO _____ (year)		

I understand that having direct contact services to people receiving services is a requirement of the position I am being considered for and that having and maintaining a satisfactory record with the Department of Human Services is a condition of my employment with American Home Health Care.

I agree to release American Home Health Care, its employees, and those who supplied you with the information from any liability for any damage which may result from furnishing the requested information or my failure to be hired for the position for which I am applying.

I certify that all elements of the personal data I have provided are true, accurate and complete. I understand and agree that any omission, false statement, misleading statement, or answer made by me on this form or any supplements to it will be sufficient grounds for rejection of employment and my discharge after employment.

I authorize American Home Health Care to submit the above information to DHS to investigate my criminal background as part of the hiring process. I have received a copy of the Privacy Notice, Acceptable Forms of Identification for DHS Background Studies, and Fingerprint and Photo Information for DHS Background Study Subjects.

_____ _____ _____

Printed Name Applicant Signature Date

AS AN EMPLOYEE OF AHHC, IT IS THE EXPECTATION OF BOTH AHHC AND THE

CLIENT THAT **YOU**:

6. Are able to work independently
7. Follow through with job responsibilities in a timely manner
8. Utilize proper lifting and body mechanics to prevent personal injury
9. Demonstrate knowledge of and adhere to all infection control procedures including proper hand washing techniques and contact with blood spills and other bodily fluids
10. Manage time effectively
11. Demonstrate knowledge and skills necessary to provide care appropriate to the age of the client
12. Provide care as directed by the client or the client's representative
13. Recognize and report changes in client's conditions to the appropriate person.
14. Document as required by the client or client representative and by AHHC
15. Display appropriate, courteous attitude and behavior (respect, support, loyalty) toward the client, the client's representative and family, and toward other staff
16. Exercise discretion and maintain confidentiality in all matters relating to the client, the client's representative and family and other staff
17. Maintain calm and professional demeanor in stressful situations
18. Limit personal phone usage
19. Wear appropriate clothing and accessories; give proper attention to personal hygiene
20. Adhere to the client's or the client's representative policy for attendance and tardiness, including providing proper notification for absences or tardiness
21. Follow the client's or client representatives directions regarding smoking while at work

Employee complete this section:

_____	_____	_____
Printed Name	Employee Signature	Date

Client/ Client Representative complete this section:

_____
Printed Name of Client

_____
Printed Name of person completing this job description

_____	_____	_____
Printed Name of Client Representative	Client/ Client Rep Signature (signifies approval of this job description)	Date

American Home Health Care LLC

APPLICATION FOR EMPLOYMENT An Equal Opportunity Employer

Federal and State laws prohibit discrimination in employment because of sex, race, creed, religion, national origin, age, handicap, marital status, status with regard to public assistance or veterans employment. We are an equal opportunity employer.

PERSONAL INFORMATION

Date _____

Name _____ **Social Security #** _____
Last First Middle

Other surnames that I have used: _____

Present Address _____
Street City State Zip County

Date of Birth: _____ **ID:** _____ **Email:** _____

Home Phone #: _____ **Alternate Phone #:** _____

How did you hear about this position? friend **Referred By:** Naima Bihi

Are you legally entitled to work in the United States? ☑ YES ☐ NO **Are you at least 18 years of age?** ☑ YES ☐ NO

In Case of Emergency Notify: _____
Name Phone # Relationship to you

U.S. Military or Naval Service _____ Rank _____ Present Membership in National Guard or Reserves? ☐ YES ■ NO

Have you ever been convicted of a crime other than minor traffic violations? ☐ YES ☑ NO
If yes, describe the nature of the crime and provide the place and date of conviction: _____

EMPLOYMENT DESIRED

Position: ☐ RN ☐ LPN/LVN ☐ Homemaker ■ Home Health Aide ☐ Staffing ☐ Clerical
☐ Personal Care Attendant ☐ Other _____

Have you passed Competency Testing? ☑ YES ☐ NO Do you have a Certificate? ☑ YES ☐ NO

Do you have a current Driver's License? ☑ YES ☐ NO Do you currently have a car? ☑ YES ☐ NO

Have you ever applied to this Company before? ☐ YES ☑ NO Where? _____ When? _____

PROFESSIONAL LICENSES, CERTIFICATION, AND REGISTRATIONS

Do you have any professional licenses, certifications and/or registrations? ☐ YES ☐ NO

License/Certificate/ Registration #:	Type	State Issued	Date Expires	Status (List Active, Inactive, Restricted, Conditional or Pending)

REFERENCES

Give below the names of three **work related** references.

NAME	ADDRESS	COMPANY/POSITION	PHONE

EDUCATION

NAME AND LOCATION OF SCHOOL		YEARS ATTENDED	GRADUATED	DEGREE/CERTIFICATION
HIGH SCHOOL			■ Yes ☐ No	
COLLEGE			■ Yes ☐ No	
COLLEGE			☐ Yes ☐ No	
ADDITIONAL TRAINING				

FORMER EMPLOYERS

List below your complete employment history for the last five years, starting with the most recent position first.
Attach additional pages if necessary.

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER SUPERVISOR'S NAME	SALARY	POSITION	REASON FOR LEAVING
FROM 11/12/2023	Amazon fulfillment center		Production associate	less hours
TO Unil now	May we contact? ■ YES ☐ NO			
FROM				
TO				
FROM				
TO				
FROM				
TO				

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for rejection or dismissal. Further, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time, with or without cause, and with or without any prior notice.

I hereby agree that, as a condition of employment by the Agency, I will promptly inform the Agency in writing of any criminal convictions, in any jurisdiction (including all pleas of guilty), other than minor traffic offenses, of which I am convicted after today.

Date_____ Signature_____

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for rejection or dismissal. Further, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time, with or without cause, and with or without any prior notice.

Date: _____ Signature: _____

American Home Health Care

VOLUNTARY SELF-IDENTIFICATION INFORMATION

American Home Health Care is an Equal Opportunity/Affirmative Action Employer. All qualified applicants will receive consideration for employment without regard to sex, race, color, national origin or ancestry, age, handicap, marital status, source of income, class, physical characteristics, sexual orientation or political beliefs.

As an employer, we comply with government regulations and affirmative action responsibilities. Solely to help us comply with government record keeping, reporting and other legal requirements, please complete this Voluntary Self-Identification Information form. This data is for analysis and affirmative action only and submission of this information is voluntary. This data will be kept in a confidential file separate from your Application for Employment.

Date_____

Position Applied For_____

Gender:

- ☐ Male
- ☐ Female
- ☐ Choose not to respond

Race/Ethnic Background:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Black / African or African American
- ☐ Hispanic / Latino
- ☐ White / Caucasian
- ☐ Two or More Races
- ☐ Choose not to respond

Veteran Status:

- ☐ Vietnam era veteran
- ☐ Disabled veteran
- ☐ Other veteran
- ☐ Non-veteran
- ☐ Choose not to respond

Disability Status*:

- ☐ Disabled
- ☐ Not disabled
- ☐ Choose not to respond

* According to the American with Disabilities Act, the term “disability” means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of that individual, a record of such an impairment, or being regarded as having such an impairment.

Employment Eligibility Verification

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

USCIS Form I-9
OMB No.1615-0047
Expires 07/31/2026

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

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

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

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

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☑ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

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

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

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

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

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

	List A	OR	List B	AND	List C
Document Title 1			MN DRIVER'S LICENSE		Social Security Card
Issuing Authority			STATE OF MINNESOTA		Social Securety Department
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

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

First Day of Employment (mm/dd/yyyy):

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
American Home Health Care LLC	2716 Portland Ave S Minneapolis MN 55407

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

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

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

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
American Home Health Care LLC 2716 Portland Ave S Minneapolis, MN 55407		81-2513308

DEPARTMENT OF REVENUE

2025 W-4MN, Minnesota Withholding Allowance/Exemption Certificate

* 2 5 2 4 6 1 *

Employees

Complete Form W-4MN so your employer can withhold the correct Minnesota income tax from your pay. Consider completing a new Form W-4MN each year and when your personal or financial situation changes. If no Form W-4MN is in effect, the number of withholding allowances claimed will be zero.

First Name and Initial	Last Name	Social Security Number

Permanent Address

City | State | ZIP Code

Marital Status *(Check one):*

- ☐ Single; Married, but legally separated; or Spouse is a nonresident alien
- ☐ Married
- ☐ Married, but withhold at higher Single rate

Complete Section 1 OR Section 2, then sign the bottom and give the completed form to your employer.

☐ Section 1 — Determining Minnesota Allowances

A Enter "1" if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if any of the following apply: . . . . . **B** _____

- You are single and have only one job
- You are married, have only one job, and your spouse does not work
- Your wages from a second job or your spouse's wages are $1500 or less

C Enter "1" if you are married. Or choose to enter "0" if you are married and have either a working spouse or more than one job. *(Entering "0" may help you avoid having too little tax withheld.)* . **C** _____

D Enter the number of dependents (other than your spouse or yourself) you will claim on your tax return. . . . . **D** _____

E Enter "1" if you will use the filing status Head of Household *(see instructions)*. . . . . **E** _____

F Add steps A through E. If you plan to itemize deductions on your 2024 Minnesota income tax return, you may also complete the Itemized Deductions and Additional Income Worksheet. . . . . **F** _____

1 Minnesota Allowances. Enter Step F from Section 1 above or Step 10 of the Itemized Deductions Worksheet . . . . . **1** _____

2 Additional Minnesota withholding you want deducted for each pay period *(see instructions)* . . . . . **2** $_____

☐ Section 2 — Exemption From Minnesota Withholding

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding *(see Section 2 instructions for qualifications)*. If applicable, check one box below to indicate why you believe you are exempt:

☐ **A** I meet the requirements and claim exempt from both federal and Minnesota income tax withholding

☐ **B** Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding, because:

- I had no Minnesota income tax liability last year
- I received a refund of all Minnesota income tax withheld
- I expect to have no Minnesota income tax liability this year

☐ **C** All of these apply:

- My spouse is a military service member assigned to a military location in Minnesota
- My domicile (legal residence) is in another state
- I am in Minnesota solely to be with my spouse. My state of domicile is _____

☐ **D** I am an American Indian that resides and works on a reservation for which I am enrolled *(see instructions)*.
Enter the reservation name: _____
Enter your Certificate of Degree of Indian Blood (CDIB)/Enrollment number: _____

☐ **E** I am a member of the Minnesota National Guard or an active-duty U.S. military member and claim exempt from Minnesota withholding on my military pay

☐ **F** I receive a military pension or other military retirement pay as calculated under U.S. Code, title 10, sections 1401 through 1414, 1447 through 1455, and 12733, and I claim exempt from Minnesota withholding on this retirement pay

I certify that all information provided in Section 1 ***OR*** *Section 2 is correct. I understand there is a $500 penalty for filing a false Form W-4MN.*

Employee's Signature | Date | Daytime Phone Number

Employees: Give the completed form to your employer.

Employers

See the employer instructions to determine if you must send a copy of this form to the Minnesota Department of Revenue. If required, enter your information below and mail this form to the address in the instructions. (Incomplete forms are considered invalid.) We may assess a $50 penalty for each required Form W-4MN not filed with us. Keep a copy for your records.

Name of Employer	Minnesota Tax ID Number	Federal Employer ID Number (FEIN)
American Home Health Care LLC	4539941	81-2513308

Address	City	State	ZIP Code
2716 Portland Ave S	Minneapolis	MN	55407

Emergency Contact Form

Employee Name		**Address**	
Phone Number			

Special Instructions:

In the event of a medical emergency, are there any emergency procedures or restrictions on medications of which emergency personnel should be aware? If yes, please explain.

Emergency Contacts:

Primary Contact in case of emergency:

Name		Relationship	
Address		Phone Number	
		Alternate Phone Number	

Secondary Contact in case of emergency:

Name		Relationship	
Address		Phone Number	
		Alternate Phone Number	

Physician Contact

Doctor's Name _____ Address _____

Phone Number _____ _____

Employee Authorization

I have voluntarily provided the above contact information and authorize A Helping Hand Senior Care Services LLC and its representatives to contact any of the above individuals on my behalf in the event of an emergency.

_____ _____

Employee signature *Date*

Employee Direct Deposit Banking Authorization Form
RUN Powered by ADP®

This form can be filled out online and printed.*
Please complete all fields.

Company Information

Company Name: American Home Health Care LLC _____ Date: _____

Employee Information Authorization

Important! Please read and sign before completing and submitting.

I hereby voluntarily authorize the Company named above (hereafter "Employer"), either directly or through its payroll service provider, to deposit any amounts owed me, by initiating credit entries to my account (s) at the financial institution (s) of my choice (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Employer, either directly or through its payroll service provider, to my account. To the extent permitted by law, in the event that Employer or its payroll service provider deposits funds erroneously into my account (s), I authorize Employer, either directly or through its payroll service provider, to debit my account for an amount not to exceed the original amount of the erroneous credit.

To the extent permitted by law, I understand that I have the right to refuse consent or revoke authorization of direct deposit at any time without fear of retaliation, and I have the right to receive any payment owed to me by other means. This authorization is to remain in full force and effect until Employer and Bank have received written notice from me of its termination in such time and manner as to afford Employer and Bank reasonable opportunity to act on it.

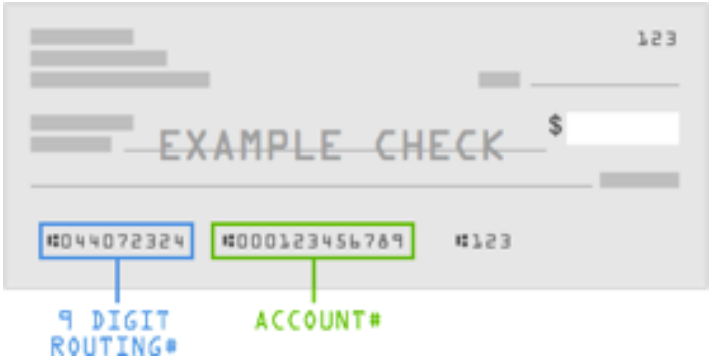
Legal Name: _____
(Last Name, First Name, Middle Initial)

Signature:_____ Date: _____

Deposit/Account Information

For a checking account, attach a voided check, not a deposit slip. If you don't have a check, ask your bank to give you the Routing Number (the nine-digit American Bankers Association (ABA) number that identifies both the Company's bank and the Federal Reserve Bank) for your account.

Note: If you have a paycard, set it up as a checking account, not a savings account. Contact the paycard issuer for the account number/routing number information.



Employee Direct Deposit Banking Authorization Form

RUN Powered by ADP®

1. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:
☑ Checking ☐ Savings

Amount to deposit in selected account:
$ _____ or ☑ Full Net Amount

2. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:
☐ Checking ☐ Savings

Amount to deposit in selected account:
$ _____ or ☐ Full Net Amount

3. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:
☐ Checking ☐ Savings

Amount to deposit in selected account:
$ _____ or ☐ Full Net Amount

4. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:
☐ Checking ☐ Savings

Amount to deposit in selected account:
$ _____ or ☐ Full Net Amount

Take advantage of Employee Access® in RUN Powered by ADP® to let your employees manage their own direct deposits.

***Attention Payroll Contact**: Employers must keep each original Employee Direct Deposit Banking Authorization form on file as long as the employee is using direct deposit, and for two years thereafter. Employers may be subject to certain federal and state direct deposit notice, authorization and record retention requirements. Please review your applicable federal, state and local laws. This form is provided for convenience only and is not meant and should not be construed as legal, HR, financial, insurance, tax or accounting advice. You should consult with your own legal counsel, human resource, accounting or other professional advisor for circumstances pertaining to your business.

APPLICANT INFORMATION RELEASE

This authorization and consent for release of personal information acknowledges that the Company and its agent may now, or at any time I am employed by the Company, conduct investigations, whether the records are of a public, private, or confidential nature.

I hereby certify that the information contained in this application form is true, correct, and complete. I understand that if any information proves to be incorrect or incomplete, grounds for the canceling of any and all offers of employment will exist and may be used at the discretion of the Company. I understand that investigative inquiries on my background, in accordance with the Fair Credit Reporting Act and all state and federal laws, will be made on me, including information as to my personal character, abilities, work habits, mode of living, residency, general reputation, performance, experience, and other qualities pertinent to my qualifications for employment, including reasons for termination of past employment.

I understand that my prospective employer may make inquiries including, but not limited to, my consumer credit history, education, professional licensing, and criminal history and driving history. Furthermore, I understand that my prospective employer and the Company may request information from various federal, state, and other agencies that maintain records concerning my past driving history, credit history, criminal history, military history, and civil and other experiences.

I understand that according to the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained by my prospective employer from a Consumer Reporting Agency. Upon written request, I will be informed whether an investigative consumer report was requested and will be given full information as to the nature and the scope of the investigation, as well as the name of the reporting agency or sources of information.

I authorize without reservation, any party (including, but not limited to, employers, law enforcement agencies, state institutions, and private information bureaus or repositories) contacted by the prospective employers from any and all liability for damages arising from the investigation and disclosure of the requested information. I further release and discharge all liability from all companies, agencies, officials, officers, employees, and other persons who, in good faith, provide to the prospective employer the above mentioned information as requested, in order to successfully complete a background investigation for my application of employment. I will allow a photocopy of this authorization to be valid as the original.

Print full name: _____

Social Security #: _____ Date of birth*: _____

Current address: _____

City/State/ZIP: _____

Driver's license #: _____

Prospective employer: _____

Applicant's signature: _____ Date: _____

** Date of birth is being requested only for the purpose of identification in obtaining accurate retrieval of records and will not be used for discriminatory purposes.*

POLICY AND PROCEDURE ON ANTI-FRAUD

I. PURPOSE

The purpose of this policy is to provide information regarding the prevention, elimination, monitoring, and reporting of fraud, abuse, and improper activities of government funding in order to obtain and maintain integrity of public funds.

II. POLICY

A holder of a license that is issued by Minnesota Department of Human Services (DHS), pursuant to MN Statutes, chapter 245A [Human Services Licensing Act], and who has enrolled to receive public governmental funding reimbursement for services is required to comply with the enrollment requirements as a licensing standard (MN Statutes, sections 245A.167 and 256B.04, subdivision 21). The company is a provider of services to persons whose services are funded by government/public funds.

Government funds may be from state or federal governments, to include, but not be limited to: Minnesota's Medical Assistance, Medicaid, Medicare, Brain Injury (BI) Waiver, Community Alternative Care (CAC) Waiver, Community Alternatives for Disabled Individuals (CADI) Waiver, Developmental Disability (DD) Waiver, Elderly Waiver (EW), and Minnesota's Alternative Care (AC) program. The company has a longstanding practice of fair and truthful dealing with persons served, families, health professionals, and other businesses. Management, staff, contractors, and other agents of the company shall not engage in any acts of fraud, waste, or abuse in any matter concerning the company's business, mission, or funds.

III. PROCEDURE

A. Definition: Types of fraud, abuse, or improper activities include, but are not limited to, the following:
   1. Billing for services not actually provided.
   2. Documenting clinical care not actually provided.
   3. Paying phantom vendors or phantom staff.
   4. Paying a vendor for services not actually provided.
   5. Paying an invoice known to be false.
   6. Accepting or soliciting kickbacks or illegal inducements from vendors of services, or offering or paying kickbacks or illegal inducements to vendors of services.
   7. Paying or offering gifts, money, remuneration, or free services to entice a Medicaid recipient to use a particular vendor.
   8. Using Medicaid reimbursement to pay a personal expense.
   9. Embezzling from the company.
   10. Ordering and charging over-utilized medical services that are not necessary for the person served.
   11. Corruption.
   12. Conversion (converting property or supplies owned by the company to personal use).
   13. Misappropriation of funds of the company or person served by the company.
   14. Personal loans to executives.
   15. Illegal orders.
   16. Maltreatment or abuse of persons served by the company.

B. Public Funds Compliance Officer: This company has designated the 3x3 as their Public Funds Compliance Officer.

C. Reporting responsibility: The company has an open door policy and encourages staff to share their questions, concerns, suggestions, or complaints regarding the company and its operations with someone who can address them properly. In most cases, this will be a staff person's supervisor. However, if the staff person is not comfortable speaking with their supervisor or is not satisfied with the supervisor's response, the staff person is encouraged to speak with the Public Funds Compliance Officer. If the staff is not comfortable speaking

with the Public Funds Compliance Officer, the staff is encouraged to speak with the owner/CEO/Board of Directors. At any time, the staff may speak with an applicable external agency to express their concerns if it is believed that it is not possible to speak with the owner/CEO/Board of Directors. Examples of applicable external agencies are local social service agency's financial manager or law enforcement. This policy is intended to encourage and enable persons to raise serious concerns within the company prior to seeking resolution outside it.

D. Requirement of good faith: Anyone filing a complaint concerning a violation or suspected violation of the law or regulation requirements must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

E. Confidentiality: Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

F. No retaliation: No staff person who in good faith reports a violation of a law or regulation requirements will suffer harassment, retaliation, or adverse employment consequences. A staff who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.

G. Report acknowledgement: The Public Funds Compliance Officer, or designee, will acknowledge receipt of the reported violation or suspected violation by writing a letter (or email) to the complainant within ten (10) business days, noting that the allegations will be investigated.

H. Responding to allegations of improper conduct: The Public Funds Compliance Officer is responsible for responding to allegations of improper conduct related to the provision or billing of Medical Assistance services. This may include, but is not limited to: investigating, interviewing applicable individuals involved, reviewing documents, asking for additional assistance, seeking input on process of the investigation, or seeking input on Medical Assistance laws and regulations interpretations to address all staff complaints and allegations concerning potential violations. The CEO will take on functions of the Public Funds Compliance Officer role if the complaint involves the 3x3. If the complaint involves both the CEO and 3x3, outside legal counsel or an applicable external agency will carry out the functions of the Public Funds Compliance Officer. The 3x3 or its designee will implement corrective action to remediate any resulting problems.

I. Evaluation and monitoring for internal compliance: On a regular schedule and as needed, the 3x3, or its designee, will run routine financial reports to review financial information for accuracy and compliance. On a regular schedule and as needed, the 3x3, or its designee, will review standard operations and procedures to ensure that they remain compliant.

J. External auditing for compliance: On a regular schedule, the company will have an external financial audit.

K. Promptly reporting errors: The Public Funds Compliance Officer shall immediately notify appropriate individuals of all reported concerns or complaints regarding corporate accounting practices, internal controls, or auditing. This may include the Chief Financial Officer, the owner/CEO, or the Chairperson of the Board of Directors. The 3x3 will promptly report to DHS any identified violations of Medical Assistance laws or regulations.

L. Recovery of overpayment: Within 60 days of discovery by the company of a Medical Assistance reimbursement overpayment, a report of the overpayment to DHS will be completed and arrangements made with DHS for the Department's recovery of the overpayment.

M. Training: Staff are trained on this policy and as needed, they may need to be re-trained. As determined by the company, staff may need to demonstrate an understanding of the implementation of this policy.

A. Documentation: The provider must maintain documentation that, upon employment and annually thereafter, staff providing a service have attested to reviewing and understanding the following statement: "It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092, and 256B.49."

It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan as authorized under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092, and 256B.49.

My signature below acknowledges this statement:

_____
Signature

_____
Date:

(Re-signed annually)

American Home Health Care LLC
2716 Portland Ave S
Minneapolis, MN 55404

POLICY AND PROCEDURES RECEIPT ACKNOWLEDGEMENT FOR EMPLOYEE TO SIGN

I have read and been informed about the content, requirements, and expectations of the policy for and procedure employees at American Home Health Care LLC

I have agreed to abide by the policy and procedure guidelines as a condition of my employment and my continuing employment at the Company.

I understand that if I have questions, at any time, regarding the policy and procedure, I will consult with my immediate supervisor or my Human Resources staff members.

Employee Printed Name: _____ Date:_____

Employee Signature:_____

American Home Health Care LLC
2716 Portland Ave S
Minneapolis, MN 55404

CLIENT GRIEVANCE / COMPLAINT FORM

I have read and been informed about the content, requirements, and expectations of the Client Grievance and Complaint process.

I understand that if I have questions, at any time, regarding the Client Grievance and Complaint process, I will consult with my immediate supervisor or my Human Resources staff members.

Employee Printed Name: _____ Date:_____

Employee Signature:_____

Minnesota Statutes, section 245A.04, subdivision 1, paragraph (d).
https://www.health.state.mn.us/facilities/regulation/ohfc/index.html

American Home Health Care LLC
2716 Portland Ave S
Minneapolis, MN 55404

Vulnerable Adult Reporting in Minnesota

I acknowledge I have reviewed and understand the reporting of Maltreatment of vulnerable adults in Minnesota

Employee Printed Name: _____ Date:_____

Employee Signature:_____

http://www.revisor.mn.gov/statues/cite/626.557#stat.626.557

https://www.health.state.mn.us/facilities/regulation/homecare/providers/maltreatment.html

American Home Health Care LLC
2716 Portland Ave S
Minneapolis, MN 55404

HIPAA

I have read and understood all of the information in the HIPAA training package and will follow all the guidelines of the privacy act laws. I will contact my supervisor or the office manager with any questions, comments, or concerns in relationship to the privacy act or my position here at Grace Home and Health Care. I do hereby certify that I will abide by every standard to protect clients' medical records and all personal health information and to ensure the confidentiality, integrity, and security of clients' records.

Employee Printed Name: _____ Date:_____

Employee Signature:_____

https://www.hhs.gov/hipaa/for-professionals/faq/index.html
http://www.hhs.gov/ocr/privacy/hipaa/npp_booklet_hc_provider.pdf

EMPLOYMENT AGREEMENT

THIS AT-WILL EMPLOYMENT AGREEMENT ("Agreement") is made and entered on (the "Effective Date") between American Home Health Care LLC ("Employer") and ("Employee"). Both parties mutually agree to the following:

ARTICLE 1
EMPLOYMENT AND SERVICES

1.1 At-Will Employment. Company shall employ Employee as a(n) Home Health Aide . Employee accepts and agrees to such employment, and agrees to be subject to the general supervision, advice and direction of Company and Company's supervisory personnel. Employee shall provide to Company the following services:

POSITION DESCRIPTION
Home Health Aide

. Participates in care conferences with other members of the health care team.
. Maintains absolute confidentiality of all information pertaining to Residents, families, and employees.
. Documents as indicated in clinical record.
. Demonstrated awareness of professional boundaries and cultural diversity
. Plans and facilitates activities for residents to enhance socialization.
. Assists with personal communication skills as needed.
. Promotes a safe and comfortable environment for the residents while respecting the resident's dignity and privacy.
. Recognizes and manages own stresses, which may affect work performance.
. Participates in in-service educational programs, as required by state regulations.
. Performs additional duties as assigned by the Director or Clinical Nurse Supervisor.
. Adheres to all agency policies.

Employee shall also perform (i) such other duties as are customarily performed by an employee in a similar position, and (ii) such other and unrelated services and duties as may be assigned to Employee from time to time by Company. You will travel and work amongst all of the company's locations as needed. While working, you will be required to devote your full business time, attention, and best efforts to the performance of your duties and to the furtherance of the Company's interests. You consent to a background check as a condition of your employment. Additional Employee responsibilities will include the duties listed in Appendix A, independently or in partnership with other staff members, as well as communication with staff and patients as might be deemed necessary in person at staff or provider meetings, or by phone or email from other locations as needs might dictate.

Employee and Employer will mutually agree as to the precise number, days and hours Employee will work, which will be based on patient demand.

ARTICLE 2
COMPENSATION AND BENEFITS

2.1 Compensation. Employee will receive as compensation the rate outlined in Appendix A. Employee will be paid according to Employer payroll practices. Upon termination of this Agreement, payments under this paragraph shall cease; provided, however, that Employee shall be entitled to payments for periods or partial periods that occurred prior to the date of termination and for which Employee has not yet been paid, and for any commission earned in accordance with Employer's customary procedures, if applicable. This section of the Agreement is included only for accounting and payroll purposes and should not be construed as establishing a minimum or definite term of employment.

2.2 Benefits. Current benefits available to the Employee are listed in Appendix A These benefits are subject to change according to Employer provider benefits policy.

ARTICLE 3
NON-COMPETE AND NON-INTERFERENCE

3.1 Covenant not to compete. Employee agrees that during the term of this Agreement and for a period of two (2) years following Employee termination of employment at Employer, Employee shall not directly or indirectly, own, manage, operate, consult or be employed by a business or company substantially similar to, or competitive with Employer within a 15 mile radius of Employer’s practice location(s) or through an Internet online presence.

3.2. Non-Interference with Employer Personnel and Patients. Employee agrees that during the term of this Agreement and for a two (2) year period immediately following the expiration or earlier termination of this Agreement, Employee shall not, in any capacity, solicit, endeavor to entice away from the Employer, perform services for, or otherwise interfere with the relationship of the Employer with either:

a) any patient of Employer, or

b) any person who is employed by or otherwise engaged to perform services for the Employer, whether as professional or non-professional personnel.

3.3 Services Unique to Employer. In addition, Employee agrees that during the term of this Agreement and for a two (2) year period immediately following the expiration or earlier termination of this Agreement, Employee shall not, in any capacity, offer or

perform any therapies, procedures, testing, or education services for pay that were learned while employed by Employer.

ARTICLE 4
CONFIDENTIAL INFORMATION

4.1 Confidential Information. For purposes of this agreement, "Confidential Information" means information that is proprietary to Employer or proprietary to others and entrusted to Employer, whether or not such information includes trade secrets. Confidential Information includes, but is not limited to, information relating to Employer's business plans and to its business as conducted or anticipated to be conducted, and to its past or current or anticipated products and services. Confidential Information also includes, without limitation, information concerning Employer patients, treatment approach, medical/health protocols, purchasing, inventory, business methods, training manuals or other materials developed for Employer training, personnel matters, research and development, accounting, marketing and selling. All information that Employer has a reasonable basis to consider as confidential shall be Confidential Information, whether or not originated by Employer and without regard to the manner in which Employee obtains access to this and any other proprietary information of Employer.

Employee shall not, during or after the termination of employment under this Agreement, (1) directly or indirectly use for the benefit of anyone other than Employer; or (2) disclose any Confidential Information to, or otherwise permit access to Confidential Information by, any person or entity not employed by Employer or not authorized by Employer to receive such Confidential Information, without the prior written consent of Employer. Employee will use reasonable and prudent care to safeguard, protect and prevent the unauthorized use and disclosure of Confidential Information.

Upon any termination of Employee employment, Employee shall collect and return to Employer all original copies and all other copies of any Confidential Information acquired by Employee while employed by Employer.

The obligations contained in this agreement will survive for as long as Employer in its sole judgment considers the information to be Confidential Information. The obligations under this agreement will not apply to any Confidential Information that is now or becomes generally available to the public without any breach of obligation by Employee or another, nor to Employee's disclosure of any Confidential Information required by law or judicial or administrative process. The confidentiality obligations in this agreement are in addition to Employee's obligations under HIPAA and any other federal or state law.

If it appears that Employee has disclosed (or has threatened to disclose) Confidential Information in violation of this Agreement, Employer shall be entitled to an injunction to restrain Employee from disclosing, in whole or in part, such Information, or from providing any services to any party to whom such Confidential Information has been

disclosed or may be disclosed. Employer shall not be prohibited by this provision from pursuing other remedies, including a claim for losses and damages.

ARTICLE 5
GENERAL PROVISIONS

5.1 Survivability and Waiver. The obligations of Articles 3 and 4 hereunder shall survive the termination of this Agreement. The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Agreement.

5.2 Modification. This agreement may not be modified or amended except written instrument signed by both parties.

5.3 Agreement. This Agreement constitutes the entire agreement and understanding between the parties hereto in reference to all the matters herein agreed upon. This Agreement replaces in full all prior employment agreements or understandings of the parties hereto, and any and all such prior agreements or understandings are hereby rescinded by mutual agreement. If any provisions of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If a court finds that any provision of this Agreement is invalid or unenforceable, but that by limiting such provision it would become valid or enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.

5.4 Compliance with Employer Rules. Employee agrees to comply with all of the rules and regulations of the Employer.

5.5 Applicable Law and Arbitration. This Agreement shall be governed by the laws of the State of Minnesota. Employer and Employee agree to submit all disputes under this Agreement to binding Arbitration under the current rules of the American Arbitration Association.

5.6 COVID-19. By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by receiving or providing services and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Company employees, contractors and agents. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience. I hereby release, covenant not to sue, discharge, and hold harmless the Company, its employees, agents, and representatives, of and from all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the

actions, omissions, or negligence of the Company, its employees, agents, and representatives. I agree to follow directions of the Company, state and federal agencies in regard to safe conduct in regard to COVID-19.

IN WITNESS WHEREOF, the parties hereto have caused this Employment Agreement to be duly executed and delivered on the day and year first above written.

Employee Signature	**Employer Signature**
_____	*Jama Mohamod* _____
Employee	Jama Mohamod Employer
_____	_____
Date	Date

CONFIDENTIALITY AGREEMENT
ACKNOWLEDGMENT OF CONFIDENTIALITY STATEMENT

I have received a copy of, read, understand, and agree to uphold the written policy on matters of confidential information and trade secrets. I also understand that in my daily job duties, I have access to confidential Company operations, and any violation of confidentiality, in whole or in part, could result in disciplinary action, up to and including termination and/or legal action.

Confidential information is defined as any information found in a patient's medical record, personal information, and work-related information. All information relating to a patient's care, treatment, or condition constitutes confidential information that is considered protected health information (PHI), and subject to all applicable federal and state laws. This confidentiality policy also encompasses any trade secret and scientific and technical information developed by the Company or its personnel.

Employees never discuss PHI with any non-employee of the Company, friends, or family members. Confidential matters involving patients are not discussed in areas where they might be overheard by other patients or other non-employees of the Company. Employees should take appropriate steps at all times to ensure that conversations regarding PHI are not overheard by others. Any unauthorized disclosure of confidential information by employees could render the Company liable for damages. Any employee who violates the confidentiality of the Company or discloses confidential medical or employee-related information is subject to disciplinary action up to and including termination.

Signed:_____ Date:_____

I understand that:

a) I will not disclose any Confidential Information during the time of my employment or at any time, to any person who has not been authorized by American Home Health Care LLC, to receive such information, and will not remove any Confidential Information from the premises without permission of American Home Health Care LLC management. I will fully comply with all confidentiality agreements between American Home Health Care LLC and its customers. I understand that misuse or disclosure of Confidential Information may result in corrective action, up to and including termination and legal action.

b) At the time I leave employment with American Home Health Care LLC, I will return all copies of correspondence, documentation, memos, patient charts or files, manuals, charts, computer software or other items or materials containing Confidential Information to American Home Health Care LLC.

c) American Home Health Care LLC is legally and contractually bound to protect the privacy and confidentiality of all such Confidential Information, and that as an associate of American Home Health Care LLC, I am also bound to that standard of confidentiality.

I HAVE READ AND UNDERSTAND THE ABOVE NOTICES REGARDING MY RESPONSIBILITIES IN UNDERSTANDING THE CONTENTS OF THIS GUIDE, AND MY UNDERSTANDING OF AMERICAN HOME HEALTH CARE LLC'S AND MY OBLIGATION REGARDING THE SAFEGUARDING OF CONFIDENTIAL INFORMATION.

Associate Name (Please Print)

Associate Signature Date

At-Will Employment Agreement and Acknowledgement of Receipt of Employee Handbook

I acknowledge that I have been provided with a copy of the American Home Health Care LLC (the "Company") Employee Handbook, which contains important information on the Company's policies, procedures and benefits, including the policies on Anti-Harassment/Discrimination, Substance Use and Abuse and Confidentiality. I understand that I am responsible for familiarizing myself with the policies in this handbook and agree to comply with all rules applicable to me.

I understand and agree that the policies described in the handbook are intended as a guide only and do not constitute a contract of employment. I specifically understand and agree that the employment relationship between the Company and me is at-will and can be terminated by the Company or me at any time, with or without cause or notice. Furthermore, the Company has the right to modify or alter my position, or impose any form of discipline it deems appropriate at any time. Nothing in this handbook is intended to modify the Company's policy of at-will employment. The at-will employment relationship may not be modified except by a specific written agreement signed by me and an authorized representative of the Company. This is the entire agreement between the Company and me regarding this subject. All prior or contemporaneous inconsistent agreements are superseded.

I understand that the Company reserves the right to make changes to its policies, procedures or benefits at any time at its discretion. However, the at-will employment agreement can be modified only in the manner specified above. I further understand that the Company reserves the right to interpret its policies or to vary its procedures as it deems necessary or appropriate.

I have received the Company Employee Handbook. I have read (or will read) and agree to abide by the policies and procedures contained in the Handbook.

Signed: _____ Date: _____

Employee

Minnesota Department of **Human Services**

BACKGROUND STUDY NOTICE OF PRIVACY PRACTICES

Because the Department of Human Services (DHS) is asking you to provide private information, you have privacy rights under the Minnesota Government Data Practices Act. This law protects your privacy, but also allows DHS to give information about you to others when the law requires it. This notice describes how your private information may be used and disclosed, and how you may access your information.

Why is DHS asking me for my private information?

A background study from the Department of Human Services (DHS) is required for your job or position. The private information is needed to conduct the background study.

How will I be notified that a background study was submitted on me?

DHS will mail you a notice within three working days after a request for a background study is submitted on you. The notice will contain the background study result or let you know that more time is needed to complete the background study. The notice will also identify the entity that submitted the background study request.

What information must I provide to complete the background study?

You are required to provide enough information to ensure an accurate and complete background study. This includes your:

- first, middle, and last name and all names you have ever been known by or used;
- current home address, city, zip code, and state of residence;
- previous home addresses, city, county, and states of residence for the last five years;
- sex and date of birth;
- driver's license or other identification number, and;
- fingerprints and a photograph.

How will the information that I give be used?

The information will be used to perform a background study that will include a check to determine whether you have any criminal records and/or have been found responsible for substantiated maltreatment of a vulnerable adult or child. Background study data is classified as "private data" and cannot be shared without your consent except as explained in this notice.

What may happen if I provide the information?

You could be disqualified from positions that require a DHS background study if you are found to have committed certain crimes, been determined responsible for maltreatment of a vulnerable adult or child, or have other records that require a disqualification. If you do not have a disqualifying record, you will be cleared to work.

What if I refuse to provide the information?

You will be disqualified if you refuse to provide information to complete an accurate background study. You will not be able to work in a position that requires a DHS background study.

Who will DHS give my information to?

DHS will only share information about you as needed and as allowed or required by law. The identifying information you provide will be shared with the Minnesota Bureau of Criminal Apprehension and in some cases the Federal Bureau of Investigation (FBI). If there is reasonable cause to believe that other agencies may have information related to a disqualification, your identifying information may also be shared with:

- county attorneys, sheriffs, and agencies;
- courts and juvenile courts;
- local police;
- the Office of the Attorney General, and;
- agencies with criminal record information systems in other states.

What information will DHS share with the entity that requested my background study?

The entity that requested the background study will be notified of your background study determination.

If you are disqualified**,** the entity will not be told the reason unless you were disqualified for refusing to cooperate with the background study or for substantiated maltreatment of a minor or vulnerable adult.

What other entities might DHS share information with?

Information about your Background study may be shared with:

- the Minnesota Department of Health;
- the Minnesota Department of Corrections;
- the Office of the Attorney General, and;
- health-related licensing boards.

What if my disqualification is set aside?

If you request reconsideration of your disqualification and your disqualification is set aside, the entity that requested the background study will be informed of the reason(s) for your disqualification unless the law states otherwise. DHS will provide information about the decision to set aside your disqualification if the entity requests it.

Unless prohibited by law, your name and the reason(s) for your disqualification will become public data if your set aside is for:

- a child care center or a family child care provider licensed under chapter 245A, or;
- an offense identified in section 245C.15, subdivision 2.

For future background studies submitted by entities that provide the same type of services as the services you were set aside for, the set aside will apply unless:

- you were disqualified for an offense in section 245C.15, subdivision 1 or 2, or;
- DHS receives additional information indicating that you pose a risk of harm, or;
- your set aside was limited to a specific person receiving services.

In addition, those entities will be informed of the reason(s) for your disqualification unless prohibited by law.

Will my fingerprints be kept?

DHS and the Bureau of Criminal Apprehension will not keep your fingerprints. However, if an FBI check is required for your background study, the Federal Bureau of Investigation (FBI) will keep your fingerprints and may use them for other purposes.

What information can the fingerprint and photo site view and keep?

The fingerprint and photo site can view identifying information to verify your identify. The fingerprint and photo site will not keep your fingerprints, photo, or most other information. The fingerprint and photo site can keep your name and the date and time your fingerprints were recorded and sent, for auditing and billing purposes.

Who can see my photo?

Your photo will be kept by DHS. If you provide your social security number to allow your background study to be transferable to future entities, your photo will be available to those entities to verify your identity.

What are my rights about the information you have about me?

- You may ask if we have information about you and request in writing to get copies. You may have to pay for copies.
- You may give other people permission to see and have copies of private information about you.
- You may ask in writing a report that lists the entities that submitted a background study request on you.
- You may ask in writing that the information used to complete your background study be destroyed. The information will be destroyed if you have:

  (1) not been affiliated with any entity for the previous two years, and;
  (2) no current disqualifying characteristic(s).

Please send all written requests to:

Minnesota Department of Human Services
Background Studies Division
NETStudy 2.0 Coordinator
PO Box 64242
St. Paul, MN 55164-0242

How long will DHS keep my background study information?

DHS will destroy:

- your photo when you have not been affiliated with an entity for two years.
- any background data collected on a you after two years following your death or 90 years after your date of birth, except when readily available data indicates that you are still living.

What is the legal authority for DHS to conduct background studies?

Background studies are completed by DHS according to the requirements in Minnesota Statutes, chapter 245C. Background studies are authorized under Minnesota Statutes, sections 256B.0943, subdivision 5a; 256B.0659, subdivision 11(a)(3); 241.021, subdivision 6(a);144.057, subdivision 1; 518.165, subdivision 4, and 524.5-118;

What if I think my privacy rights have been violated?

You may report a complaint if you believe your privacy rights have been violated. If you think that the Minnesota Department of Human Services violated your privacy rights, you may send a written complaint to the Minnesota Department of Human Services, Privacy Official at:

Minnesota Department of Human Services
Privacy Official
PO Box 64998
St. Paul, MN 55164-0998

Updated: 02/12/2015

American Home Health Care

Policy Receipt and Signature Page

Orientation to the following policies was received within 24 hours of admission, or 72 hours for persons who would benefit from a later orientation:

_____ Maltreatment of Vulnerable Adults/Minors including:

- Telephone number of the common entry point

_____ Program Abuse Prevention Plan

I have been informed of and provided copies of the following policies and procedures affecting a person's rights under section 245D.04 within 5 days of service initiation:

_____ Grievance Policy
_____ Service Suspension
_____ Service Termination
_____ Emergency Use of Manual Restraint
_____ Drug and Alcohol Prohibition*
_____ Admission Criteria*
_____ Data Privacy*
_____ Universal precautions and sanitary practices*
_____ Incident Response, Reporting, Review Policy*
_____ Emergency Response, Reporting, and Review*
_____ Safe medication Assistance and Administration*
_____ Medication Assistance and Administration*
_____ Safe Transportation*

* Required for intensive services

Name	Signature	Title	Date
		Employee	
		Provider	

American Home Health Care

EMPLOYEE JOB PERFORMANCE EVALUATION *CONFIDENTIAL*

EMPLOYEE NAME _____ JOB TITLE _____

DATE OF HIRE _____

EVALUATOR _____ PERIOD OF EVALUATION:

DATE OF EVALUATION: _____ FROM: _____ TO: _____

JOB KNOWLEDGE			
1	2	3	4
Lack of knowledge & understanding of job duties; needs frequent instruction.	Insufficient knowledge of job duties; requires help with some job function.	Good knowledge of job; able to perform within job description; responds well to suggestions.	Excellent understanding of job; works within job description; seeks help appropriately

Comments:

_____

_____

QUALITY OF WORK (Accuracy, neatness, thoroughness)			
1	2	3	4
Poor quality; frequent errors; requires excessive checking and rework	Inconsistent; makes careless mistakes; requires more than acceptable amount of direction & supervision.	Work usually accurate & neat; few errors; follows instruction well.	High quality work; consistently neat & accurate; works independently.

Comments:

_____

_____

QUANTITY OF WORK (Ability to complete work in prescribed time)			
1	2	3	4
Insufficient quantity; slow; does not always finish assignment; has problems organizing work	Work at slow pace; meets minimal requirements.	Output is good; completes tasks in reasonable time & uses time effectively.	Output high; starts promptly & uses time well; organizes; does more than required.

Comments:

_____

_____

ATTITUDE (Personality, temperament, cooperation, loyalty toward others)			
1	2	3	4
Difficult to work with; uncooperative & rude at times; indifferent toward job.	Some difficulty working with staff or clients; occasionally unwilling to follow orders.	Enjoys job; gets along with co-workers/clients; respectful of supervision.	Enthusiastic; motivated toward work & the agency; well liked; cooperative; promotes good will.

Comments:

_____

_____

DEPENDABILITY (Acceptance of responsibility and duties)			
1	2	3	4
Frequently neglects accepted assignments; occasionally late; shows little effort; gives up easily	Sometimes unreliable; satisfied to meet minimum requirements; needs reminders to complete tasks in timely manner.	Prompt; trustworthy & reliable; needs average direction; completes assigned tasks.	Very reliable persistent; completes task in spite of difficulties; good follow through.

Comments:

American Home Health Care

INITIATIVE			
1	2	3	4
Does less than expected; does not volunteer or help with extra assignments.	Needs reminding to complete expected tasks; does only what is requested.	Shows initiative in identifying personal/company needs; reports changes or concerns; takes opportunity to increase knowledge	Readily assumes duties as necessary; takes opportunities to improve knowledge, works with co-workers enhance company image

Comments:

PERSONAL APPEARANCE			
1	2	3	4
Unsatisfactory appearance; does not adhere to dress code;	Occasionally untidy and careless about appearance;	Follows appropriate dress code; careful about personal appearance; dresses appropriately.	Well groomed; very neat & appropriately dressed; follows dress code.

Comments:

PUBLIC RELATIONS (Attention individual gives others)			
1	2	3	4
Discourteous & rude	Sometimes tactless; inappropriate language & tone of voice	Agreeable & pleasant; willing to help; represents company well	Always courteous & pleasant; respectful of clients & co-workers

Comments:

PARTICIPATION IN CONTINUING EDUCATION/Personal and professional growth activities.			
1	2	3	4
Does not attend regular meetings/in-services.	Attends mandatory meetings/programs; needs encouragement to identify interests, needs	Attends in-services, programs or meetings as required. Interested in new information and responsibilities.	Participates in planning & identifying needs. Motivated and enthusiastic.

Comments:

OVERALL EVALUATION	POOR		BELOW AVERAGE		AVERAGE		ABOVE AVERAGE	

EVALUATOR SUGGESTIONS FOR IMPROVEMENT:

EMPLOYEE COMMENTS	DATE

EVALUATOR SIGNATURE	DATE
EMPLOYEE SIGNATURE	DATE

American Home Health Care

	Competent to perform all assigned job duties:	Performance improvement plan required:	Timeline for completion of performance involvement plan:	Supervisor signature	Employee Signature
Date of Evaluation:	▫ yes ▫ no	▫ yes ▫ no			
Date of Evaluation:	▫ yes ▫ no	▫ yes ▫ no			
Date of Evaluation:	▫ yes ▫ no	▫ yes ▫ no			

By signing here, I verify that the above training has been provided to me.

Employee signature Date

American Home Health Care

Employee Name:_____

Position/Title: Home Health Aide

Date: _____

Acknowledgement of Job Duties and Responsibilities

As an employee providing 245D services, you are entrusted with ensuring the highest standards of care and compliance. Please read and acknowledge your understanding of the following duties and responsibilities:

1. Client Care and Support
   - Assist clients in activities of daily living (ADLs) including but not limited to bathing, dressing, grooming, and meal preparation.
   - Support clients in maintaining personal hygiene and health, including assistance with medication management as per individual care plans.
   - Promote and encourage clients' independence, while providing necessary assistance to ensure safety and well-being.

2. Individualized Support Plans Implementation
   - Follow and implement the individualized support plans developed for each client, ensuring that all activities align with their specific needs, goals, and preferences.
   - Regularly review and update support plans in collaboration with the designated manager/coordinator to reflect any changes in the client's condition or goals.

3. Documentation and Reporting
   - Maintain accurate and timely records of client care, services provided, and any changes in the client's condition or behavior.
   - Report any incidents, concerns, or significant changes in clients' conditions to the designated manager/coordinator immediately.
   - Ensure all documentation complies with 245D licensing requirements and company policies.

4. Compliance with Policies and Procedures
   - Adhere to all Company policies, procedures, and standards, including those related to 245D licensing.
   - Participate in regular training sessions, meetings, and evaluations to stay informed about best practices, regulatory changes, and company updates.

- Maintain confidentiality and protect clients' rights and privacy in accordance with HIPAA and other relevant regulations.

5. Health and Safety
   - Ensure a safe and clean environment for clients by adhering to health and safety protocols.
   - Utilize proper techniques and equipment when assisting clients to prevent injury to both clients and staff.
   - Report any safety hazards or concerns to the designated manager/coordinator promptly.

6. Professional Conduct
   - Demonstrate professionalism and respect in all interactions with clients, their families, coworkers, and other stakeholders.
   - Communicate effectively and empathetically, addressing clients' needs and concerns with patience and understanding.
   - Uphold the values and mission of the company, promoting a positive and supportive work environment.

Acknowledgement and Signature

I have read and understood my job duties and responsibilities as outlined above. I acknowledge that it is my responsibility to comply with these duties and to seek guidance from my supervisor if I have any questions or need further clarification. I understand that failure to adhere to these responsibilities may result in disciplinary action, up to and including termination of employment.

Employee Signature: _____ Date: _____

Provider/Manager Signature: _____ Date: _____

Thank you for your commitment to providing exceptional care and support to our clients.