ORIENTATION CHECKLIST

Staff Name: _____ Date of Hire: _____

X	EMPLOYMENT/HIRE	DATE SUBMITTED
	Bella Employment Application	
	Resume	
	Objectives & Philosophy	
	Criminal Background Consent Form	
	Signed Job Description	
	Confidentiality Statement	
	Emergency Preparedness	
	W-4	
	Cultural Awareness	
	Emergency Contact Information	
	Infection Control Practices/Measures	
	Client's Rights	
	I-9	
	Personal Policies	
	HHA or PCA Certification	
	Social Security Card	
	Driver's License	
	Proof of Citizenship, Work Permit, Green Card	

X	CLINICAL COMPETENCY	DATE SUBMITTED
	Professional License Verification	
	TB Test Results	
	CPR Certification	
	Training/Award Certificates	
	Medical Assessment	

Application for Employment

Employees of the Bella Home Service, LLC. and applicants for employment shall be afforded equal opportunity in all aspects of employment without regard to race, color, religion, political affiliation, national origin, disability, marital status, gender, or age.

*Position applied for*_____

1. First Name: _____ Last Name: _____ MI._____

2. SSN:_____/_____/_____. D.O.B: _____

4. Address: _____City_____State_____Zip Code_____

5. Home Phone: _____6. Cell Phone / Pager: _____Email_____

7. EDUCATION

a. Circle highest high school grade completed 1 2 3 4 5 6 7 8 9 10 11 12 and Year Completed _____

b. If you not completed high school, do you have equivalency diploma? Yes __No__Date Received _____

c. Circle number of years of post high school education 1 2 3 4 5 6 7

	Name & Location of Institution	Hrs	Degree Received	Major	Minor	Dates Attended
1						
2						
3						

9. **EXPERIENCE** —Use Supplementary Experience Form(s) for additional space. Starting with the most recent, describe ALL paid, military and applicable voluntary experience. Highlight your knowledge, skills and abilities which best demonstrate your qualifications for this position. You may list significantly different jobs within the same organization as separate items. May we contact your present supervisor? Yes ___No ___

a. Job Title: _____**Duties:** _____

Employer: _____Phone: _____Type of business: _____

Address: _____

Immediate supervisor: _____Salary (start): _____ (finish)_____

Dates Start (mo/yr) _____/_____to (mo/yr): _____/_____ Reason for leaving _____

Full-time: _____ Part-time: _____ Hours/week: _____

a. Job Title: _____**Duties:** _____

Employer: _____Phone: _____Type of business: _____

Address: _____

Immediate supervisor: _____Salary (start): _____ (finish)_____

Dates Start (mo/yr) _____/_____to (mo/yr): _____/_____ Reason for leaving _____

Full-time: _____ Part-time: _____ Hours/week: _____

c. Use this space for any additional information you think would help us evaluate your application, including training, seminars, workshops, special achievements or specialized skills:_____

_____

d. License (to include driver's), certificate or other authorization to practice a trade or profession.

	Type License Number	Expiration Date	Granted by (licensing board)
1			
2			
3			

10. **REFERENCES**

List names, addresses and relationships of three (two professional and one social acquaintance) persons not related to you who know your qualifications:

	Name	Address Phone	Relationship
1			
2			
3			

11. **MISCELLANEOUS**

a. Check which shift you will accept: ___ Day ___ Evening ___ Night ___ Rotating ___ Weekends Specify shift hours _____

b. Check, which job status you would accept: ___ Full-time ___ Part-time (specify) :_____

c. For purposes of compliance with the Immigration Reform and Control Act, are you legally eligible for employment in the United States? ___ Yes ___ No.

d. Are you willing to provide your own transportation if necessary for your employment? ___ Yes ___ No.

e. Have you ever been convicted* for any violation(s) of law? ___ YES ___ NO. If YES, please provide the

following: Description of offense: _____

Statute or ordinance (if known): _____Date of Charge: _____ Date of Conviction:

_____County, City and State of Conviction: _____

(For additional convictions use plain paper. Include all information listed above.)

* Convictions include Virginia juvenile adjudications for Capital Murder, First and Second Degree Murder, Lynching or Aggravated Malicious Wounding, if you were age fourteen (14) to eighteen (18) when charged.

12. When will you be available to start work? (No date is necessary if you are available as soon as you give two (2)

weeks notice.) ___ Month ___ Day ___ Year.

13. **CERTIFICATION—** *Each Application Requires Current Date and Original Signature I hereby* certify that all entries on both sides and attachments are true and complete, and I agree and understand that any falsification of information herein, regardless of time of discovery, may cause forfeiture on my part of any employment in the service of the Bella Home Care Service ,LLC. I understand that all information on this application is subject to verification and I consent to criminal history background checks. I consent to comply with Bella Home Care Service LLC. Policy on a drug and alcohol free workplace environment and will comply to provide evidence of compliance if requested at any time during work. I also consent to references and former employers and educational institutions listed being contacted regarding this application. I further authorize the Bella Home Care Service, LLC. To rely upon and use, as it sees fit, any information received from such contacts. Information contained on this application may be disseminated to other agencies, nongovernmental organizations or systems on a need to- know basis for good cause shown as determined by the agency head or designee. I consent to comply

Date_____ Applicant Signature_____

Print Name_____

FOR OFFICE USE ONLY

Hired Date	Start Date	Salary/Wage

Remarks

END

THE PHILOSOPHY AND OBJECTIVES OF BELLA HOME CARE SERVICES

PHILOSPOHY

Bella Home Care is to improve the health and wellbeing of our customers through the provision of quality, cost-effective health care services and products.

We will accomplish our goals by fostering an environment in which our employees support and advance our mission enthusiastically.

OBJECTIVES

To attain the highest quality of life for our patients by providing personal, efficient, and effective care in the home care setting

To assist patients in achieving their optimal level of independence, and maintain active and productive lives

To provide home health care, thus allowing patients to recover and/or rehabilitate in the comfort of their own homes

To allow patients to remain at home with their families as long as possible

To assist family members and/or patients in acquiring the health care needed and to provide them with appropriate referrals.

BELLA HOME CARE SERVICE, LLC

CRIMINAL HISTORY SEARCH
CONSENT FORM

NAME:_____ DATE:_____

I,_____, have had no prior convictions of an offense described in the **Health And Safety Code** which would bar or potentially bar employment as listed below.

CRIMINAL HOMICIDE **KIDNAPPING & FALSE**

INDECENCY WITH A CHILD **IMPRISONMENT TO ABDUCT FROM**

CUSTODY **SALE OR PURCHASE OF A CHILD**

SOLITATION OF A CHILD **ROBBERY**

ARSON **ASSULTIVE OFFENSES**

AGGRAVATED ROBBERY **THEFT**

BURGLARY & CRIMINAL TRESPASS **FRAUD**

WEAPONS **INDECENT EXPOSURE**

PUBLIC LEWDNESS

PUBLIC INDECENCY **A FELONY VIOLATION OF A STATURE INTENDED TO CONTROL THE POSSESSION OR DISTRUBUTION OF A SUBSTANCE (VIRGINIA CONTROLLED SUBSTANCE ACT)**

I UNDERSTAND THAT THE HOME CARE AGENCY IS REQUIRED TO CONDUCT A CRIMINAL HISTORY CHECK WITHIN 30 DAYS OF EMPLOYMENT. I, THE UNDERSIGNING, HEREBY AUTHORIZE THIS AGENCY TO CONDUCT AND VERIFY MY CRIMINAL HISTORY BY PERFORMING A CRIMINAL HISTORY CHECK.

_____ _____

SIGNATURE OF EMPLOYEE ***SIGNATURE OF EMPLOYER***

JOB DESCRIPTION
Home Health Aide (HHA)

JOB SUMMARY:

A paraprofessional person who is specifically trained, competent and performs assigned functions of personal care to the patient in their residence under the direction, instruction and supervision of the registered nurse (RN).

QUALIFICATIONS:

1. Must meet Medicare Conditions of Participation for Home Health Aide training program and competency.
2. Have a sympathetic attitude toward the care of the sick and elderly.
3. Ability to carry out directions, read and write.
4. Maturity and ability to deal effectively with the demands of the job.

RESPONSIBILITIES:

1. Understands and adheres to established Agency policies and procedures.
2. Performs personal care and bath as ordered.
3. Completes appropriate visit records in a timely manner as per Agency policy.
4. Reports changes in the patient's condition and needs to the RN.
5. Performs household services essential to health care in the home as assigned.
6. Ambulates and exercises the patient as assigned.
7. Performs simple procedures as an extension of the therapy services, e.g., range of motion (ROM) exercises as assigned.
8. Assists with medications that are ordinarily self-administered as assigned.
9. Attends inservice and continuing education programs as scheduled and necessary.
10. Attends patient care conferences as scheduled.

WORKING ENVIRONMENT:

Works indoors in Agency office and patient homes and travels to/from patient homes.

JOB RELATIONSHIPS:

1. Supervised by:	Director of Clinical Services/Nursing Supervisor/RNs, PTs, OTs, SLPs

Job Description – Home Health Aide

(HHA)...continued RISK EXPOSURE:

High risk

LIFTING REQUIREMENTS:

Ability to perform the following tasks if necessary:

- Ability to participate in physical activity.
- Ability to work for extended period of time while standing and being involved in physical activity.
- Heavy lifting.
- Ability to do extensive bending, lifting and standing on a regular basis.

I have read the above job description and fully understand the conditions set forth therein, and if employed as a Home Health Aide, I will perform these duties to the best of my knowledge and ability.

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

The trade secrets, proprietary information and other internal information, data and materials the ("Confidential Information") of Bella Home Care LLC; its subsidiaries and affiliates (collectively, "Bella Home Care Service,") are valuable assets. Protection of this information plays a vital role in Bella Home Care's continued growth and its ability to compete. Therefore, in consideration of the wages and salary to paid, employee agrees to the following:

1. Employee' Acknowledgment of the importance of Non-disclosure. Employee acknowledges that the Confidential Information to which Employee shall have access as a result of Employee's employment at Bella Home Care in confidential, unique and valuable and was developed by or for Bella Home Care at substantial cost and over a period of time. Employee acknowledges that disclosure of such confidential information to anyone other than persons authorized by Bella Home Care would cause Bella Home Care irreparable injury.
2. Employee Agreement Not to Disclose Confidential Information. Employee agrees that in order to appropriately safeguard this confidential information.

(a) Employee will not directly or indirectly disclose to any other person other than Bella Home Care's directors and officers or other persons, including employees authorized by Bella Home Care, or use of otherwise exploit for the employee's own benefit or for the benefit of anyone other than Bella Home Care, any Confidential information whether such material is developed before or after the date of this Agreement or employee's employment with Bella Home Care.

(b) Employee shall use his or her best efforts to cause all persons or entities to whom any Confidential information shall be disclosed by him or her hereunder to observe the terms and conditions set forth herein as though each such person or entity were bound hereby;

(c) Employee shall remove any Confidential information from Bella Home Care's premises except in the course of performing his or her duties on behalf of Bella Home Care; and

(d) Employee shall have no obligation hereunder to keep confidential any Confidential Information if and to the extent disclosure of any such information is specifically required or allowed by applicable law, pursuant to an order of a court or administrative agency, or if the information has been released to the public by Bella Home Care, however, that in the event disclosure is required by a subpoena or an order of a court or administrative agency, employee shall provide Bella Home Care with prompt notice of

such requirement, prior to making any disclosure, so that Bella Home Care may seek protective order. Furthermore, nothing herein shall be constructed as to prohibit employee from disclosing employee's own personal pay, benefits data or company policies and procedures, including manuals and forms, as may be specifically permitted by federal law.

3. Information, Data and materials constituting confidential information. Confidential information includes, but not limited to, such items as:

   (a) Any patent, patent application copyright, trade name, service mark, service name, "know-how" or trade secrets;
   (b) Individuals we serve and information relating to any such individual or any party related thereto;
   (c) Customer lists and information relating to any client of Bella Home Care or any party related thereto;
   (d) Supplier lists, pricing policies, consulting contracts and competitive bid information;
   (e) Company records, operational methods and company policies and procedure, including manuals and forms.
   (f) Marketing data, plans and strategies;
   (g) Business acquisition, development expansion or capital investment plan or activities;
   (h) Software and any other confidential technical programs;
   (i) Personnel information, employee payroll and benefits data;
   (j) Accounts receivable and accounts payable;
   (k) Other financial information, including financial statements, budgets, projections, earnings and any unpublished financial information;
   (l) Company correspondence and communication with outside parties; and
   (m) Information data and materials developed by employee.
4. Assignment of Intellectual Property Rights to Bella Home Care. Employee agrees to assign and transfer to Bella Home Care his or her entire right, title and interest in and to any and all improvements, new ideas or concepts or other innovations made or developed by employee (the "innovator") either solely or jointly with other during the course of employment. Employee agrees to make and maintain adequate and written records of all such innovations in the form of notes or reports relating thereto; which records shall be and remain the property of and be available to Bella Home Care at all times. Employee agrees to promptly disclose to Bella Home Care all such innovations and shall not claim any additional or special payment for such assignment.
5. Return of Confidential Information upon Termination. Upon termination of employment for whatever reason, employee agrees to return immediately to Bella Home Care (employee's Supervisor) any and all confidential information, including copies, extract or other reproductions in employee's possession or control.

6. Agreement Does Not Constitute Contract of Employment. Employee acknowledges that this Agreement addresses only the treatment of Confidential Information and does not constitute a contract or employment nor does it agree and continued employment of employee by Bella Home Care Service, LLC.
7. Survival. The termination of employee's employment, for whatever reason, shall not extinguish any obligations of Employee hereunder,
8. Enforcement of Agreement. Bella Home Care shall be entitled to specific performances and injunctive or other equitable relief or any breach of this agreement.

IN WITNESS WHEREOF, Employee has signed this Agreement as of the written below.

_____

Print Name

_____ _____

Employee Signature Date

8989 Cotswold Dr. Suite 7. Burke VA 22015
Phone: 703-323-4912 * Fax 703- 323-4914 * www.Bellahomecare.com

CLIENT'S RIGHTS.

1. The right to receive service with out regarding to race creed color, sex, age or disability.
2. The right to receive written information about rights in advance of receiving care or during the initial evaluation visit before the initiation of treatment, including what to do if rights are violated;
3. The right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services. The provider must advice the recipient in advance of the right to participate in planning the care or treatment.
4. The right to be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequences of these choices including the consequences of refusing these services;
5. the right to be told in advance of any change in the plan of care and to take an active part in any change;
6. The right to refuse services or treatment;
7. The right to know, in advance, any limits to the services available from a provider, and the provider's grounds for a termination of services;
8. The right to know and be advised in both orally and in writing, in advance of receiving care whether the services are covered by health insurance, medical assistance and other programs, how much charges it will covered and how much charges that the individual may have to pay; The Provider must advise the recipient of
9. Home care services, both orally and in writing, of any changes in such coverage and the recipient's liability for charges as soon as possible, but no later than 30 calendar days after the provider becomes aware of the charges.
10. The right to know what the charges are for services, no matter who will be paying the bill;
11. The right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, medical assistance, or other health programs;
12. The right to have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information;
13. The right to be allowed access to records and written information from records.
14. The right to be served by people who are properly trained and competent to perform their duties;
15. the right to be treated with courtesy and respect, and to have the patient's property treated with aspect;
16. the right to reasonable, advance notice of changes in services or charges, including at least ten days' advance notice of the termination of a service by a provider, except in cases where:
    (a) The recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services; or
    (b) An emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider;
17. The right to a coordinated transfer when there will be a change in the provider of services;
18. (a) The right to voice grievances regarding treatment or care that is, or fails to be, furnished, or regarding the lack of courtesy or respect to the patient or the patient's property;
    (b) Assured the right to voice grievances and complaints related to organizational services without fear of reprisal.
    (c) Provided with advance directive information prior to start of services.

19. The rights to know how to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigates and attempt to resolve the grievance or complaint. The provider shall document in writing, all complaints, as well as document, in writing any resolution of the complaint against anyone furnishing service on behalf of the provider.
20. The right to know the name and address of the state or county agency to contact for additional information or assistance;
21. The right to assert these rights personally, or have them asserted by the patient's family or guardian when the patient has been judged incompetent, without retaliation.
22. The right to be informed of the agency's liability insurance; to include employee personal injury.
23. Free from mental and physical abuse and property exploitation.
24. The nature and frequency of service to be delivered, the purpose of the service, and any side effects or hazards of which the patient should be aware.
25. The refund policies of the agency.

IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING YOU HOME CARE SERVICES, YOU MAY CALL, WRITE, OR VISIT THE OFFICE OF HEALTH FACILITY COMPLAINT, VIRGINIA DEPARTMENT OF HEALTH. YOU MAY ALSO CONTACT THE OMBUDSMAN FOR ALDER VIRGINIANS.

BELLA HOME CARE SERVICE, LLC. FOR EMERGENCY Call **911** 8989 Cotswold Dr Suite 7 Burke VA 22015 TEL: (703) 323-4912 FAX: (703) 323-4914	**Office of Licensure and Certification** Virginia Department of health 9960 Mayland DR – suite 401 Richmond , Virginia 23233 (804) 3672100
DEPT. FOR AGING, LONG-TERM CARE OMBUDSMAN 24 East Cary Street, Suite 100, Richmond, VA 23219 (804) 565-1600 Fax: (804) 644-5640	

8989 Cotswold Dr., Burke, VA 22015 ♦ Tel: 703-323-4912 Fax: 703-323-4914
url: www.bellahomecare.com ♦ e-mail: info@bellahomecare.com

EMERGENCY PREPAREDNESS PLAN

PURPOSE
To establish a plan this will allow for the continuation of services in the event of a major disaster.

POLICY:
In the event of emergency disaster situations that could adversely affect delivery of care, the agency will implement a plan designed to minimize disruption of agency services and provide for the care of priority patients. The overall plan considers the agency's commitment to provide service while ensuring the safety of its employees. All staff are expected to be available for work unless the agency is officially closed. Closure of the agency will be determined by instructions from the Emergency Broadcast System.

1. The agency will identify radio station and office cell phone numbers in advance.

2. Emergency situations include, but are not limited to:
   a) Severe weather, i.e., heavy rains, ice storms, blizzards, etc.
   b) Natural disasters, i.e., flood, tornado, hurricane, earthquake, etc.
   c) Major industrial or community disaster, i.e., power outage, fire, roadblocks, etc.
   d) Labor/strike conditions
   e) Terrorist activity
   f) Agency personnel illness affecting significant number of personnel.

3. The decision to implement the emergency preparedness plan shall be made by the Administrator or designee upon becoming aware of any emergency situation.

4. The Clinical Director and HR Coordinator/Receptionist shall be responsible for triaging all client care according to the following categories:

a) *Category 1:* Replacement staff member is essential. Clients who cannot safely forego care and require health care intervention regardless of other conditions. Clients in this category may include highly unstable clients with a high probability of inpatient admission if home care is not provided, IV therapy clients, highly skilled wound care, etc. Clients who need total assistance with ADL's with no family back-up support available.

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b) *Category 2:* Replacement staff member somewhat essential. Client needs partial assistance and there is family back-up support available.

Category 3: Replacement staff member not essential. Client who can safely forego care or a scheduled visit without a high probability of harm or deleterious effects; this category may include homemaker clients, routine supervisory visits, clients with frequencies of I or 2 times a week if health status permits, or if a competent family/caregiver is present.

PROCEDURE

The admitting professional:

1. Assigns a Category rating of 1, 2, or 3 at the initial visit according to the criteria.
2. Documents the assigned rating emergency disaster sheet
3. Plans with and educates the patient and family for response to potential emergencies including emergency contact numbers, transport options, evacuation routes, local shelters, back up systems for equipment and several days supply of food, medications and medical supplies.
4. Reassesses client's staffing needs according to the criteria, as necessary, on an ongoing basis.

Management Responsibilities:

1. Once the decision has been made to implement the emergency preparedness plan, the Administrator or designee shall initiate the Pyramid Phone Communication Plan.
2. Following the initiation of PPCP, all available and qualified personnel shall be mobilized to perform home care as needed to prevent staffing deficits.
3. The clinical supervisor and designee(s) shall assign all available, qualified personnel to care for first, Category 1 clients and second, Category 2 clients. Category 3 clients and any Category 2 client who do not receive scheduled care services shall be notified by phone as soon as possible.
4. Alternate transportation for staff will be implemented as needed.

New clients shall not be accepted for care until the emergency situation is controlled or staffing levels permit. Clients accepted, but not yet admitted, shall be triaged as noted above.

PROLONGED EMERGENCY

In the event of a prolonged emergency situation, the Administrator and/or designee

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shall:

1. Determine staffing availability and limitations including assistance available from external staffing agencies.
2. Identify those clients who can be discharged from home care earlier than anticipated
3. Determine course of action based on above information.
4. Identify clients with continuing care needs.
5. Contact other area home care organizations to determine degree to which they may accept new clients if the decision is made to transfer.
6. Notify attending physicians, regarding recommendations for continued care for clients on caseloads.
7. Make transfer or discharge arrangements as indicated, notifying clients and families/caregivers as appropriate.
8. The agency shall retain only those clients for which it can safely and adequately provide care.
9. Safety of clients and agency personnel shall take priority in all emergency situations.
10. Weather and road conditions shall be monitored via local weather reports and state patrol reports.

Natural or community disasters shall be monitored via the Emergency Broadcasting System, reports from local authorities and reports from other local health care facilities.
In all emergency situations, the Administrator or designee shall maintain communications and act as the spokesperson between other facilities, media, and safety authorities.
All staff will be educated regarding the emergency preparedness plan in initial orientation and as part of the annual required in-service training. This includes an annual fire drill and emergency evacuation procedure.

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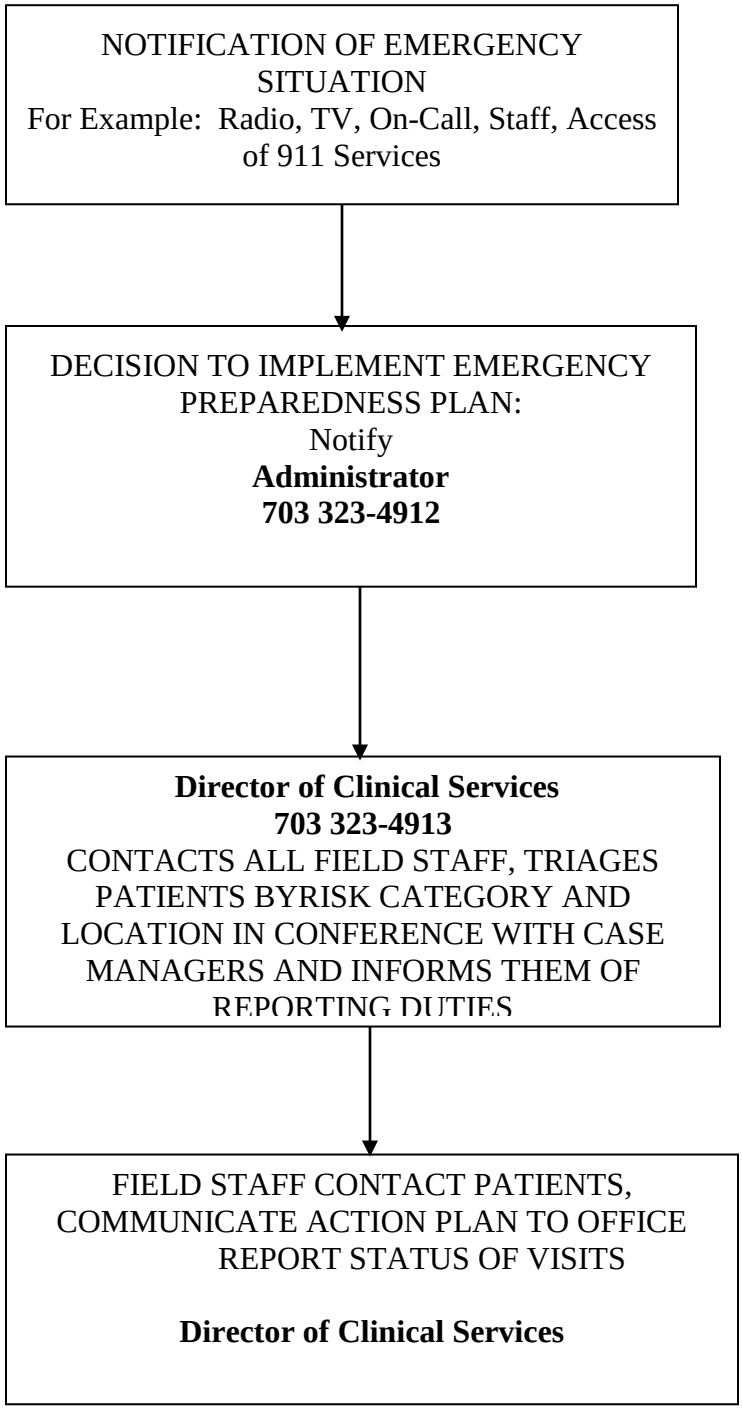
Emergency Preparedness Plan
Telephone Tree



BELLA HOME CARE LLC. CODE OF CONDUCT

A professional relationship with a client includes

- Maintaining a positive attitude.
- Being cleanly and neatly dressed and groomed
- Arriving on time doing tasks efficiently and leaving on time
- Finishing an assignment
- Doing only the tasks assigned
- Keeping all clients' information confidential
- Speaking politely and cheerfully to the client even if you are not in a good mood
- Never cursing or using profanity, even if the client does
- Never discussing your personal problems
- Not giving or accepting gifts
- Calling the client "Mr.", "Ms.", "Mrs", or "Miss" and his or her last name, or by the name he or she prefers
- Listening to the client
- Always explaining the care you will provide before providing it
- Always following care practices, such as hand washing, to protect yourself from the client

A professional relationship with an employer includes

- Maintaining a positive attitude
- Completing assignments efficiently
- Consistently following policies and procedures
- Documenting and reporting carefully and correctly
- Communicating problems with clients or assignments
- Reporting anything that keeps you from completing assignments
- Asking questions when you do not know or understand something
- Taking directions or criticism without getting upset
- Always being on time
- Participating in education programs offered
- Being a positive role model for your agency at all times Home health aides must be compassionate, honest, conscientious, dependable, respectful, cordial, and tolerant

I have read, understand, and will comply with Bella Home Care Service LLC. Drug and Alcohol Free Workplace Environment Policy

Date_____

Applicant Signature_____

Print

Name_____

DRUG AND ALCOHOL FREE WORKPLACE POLICY

Bella Home Care Service LLC maintains a drug free and non-smoking work environment.

Policy Statement – Bella Home Care Service LLC is committed to providing a safe work environment and to fostering the well-being and health of its Employees. That commitment is jeopardized when any Bella Home Care Service LLC Employee illegally uses drugs or alcohol on the job, comes to work with these substances present in his/her body, or under the influence, or possesses, distributes, or sells drugs in the workplace. The intent of this policy is to offer a helping hand to those who need it, while sending a clear message that Bella Home Care LLC has a zero tolerance policy on illegal drug and alcohol use.

It is a violation of Bella Home Care LLC policy for any Employee to:

- Possess, sell, trade, or offer for sale illegal drugs or otherwise engage in the illegal use of drugs or alcohol, or attempt or assist another to do so while in the course of employment or engaged in a Bella Home Care Service LLC- sponsored activity while on Bella Home Care LLC or Client property or in a Bella Home Care LLC or client-owned, leased or rented vehicle.

- Report to work or conduct Bella Home Care Service LLC business on Bella Home Care Service LLC or Client property or in a Bella Home Care Service LLC or Client-owned, leased, or rented vehicle under the influence of illegal drugs or alcohol (with illegal drugs or alcohol in his/her body)

- Use prescription drugs illegally. However, nothing in this policy precludes the appropriate use of legally prescribed medication.

Employees should report to work fit for duty and free of any adverse effects of illegal drugs or alcohol. This policy does not prohibit Employees from the lawful use and possession of prescribed medications. Employees must however, consult with their doctors about the medications' effect on their fitness for duty and ability to work safely and promptly disclose any work restrictions to their Manager. Employees should not however, disclose underlying medical conditions unless directed to do so. If needed Employees may consult Human Resources for a possible reasonable accommodation under the ADA Law.

Bella Home Care Service LLC will also not allow any Employee to perform their duties while taking prescribed drugs that are adversely affecting the Employee's ability to safely and effectively perform their job duties. Employees taking a prescribed medication must carry it in the container labeled by a licensed pharmacist or be prepared to produce this if asked.

Violations of this policy are subject to disciplinary action up to and including terminations.

As a condition of employment, Employees must abide by the terms of this policy and must notify Bella Home Care Service LLC in writing of any conviction or violation of a criminal drug statue occurring in the workplace no later than 5 calendar days after such conviction. Although

adherence to this policy is considered a condition of employment nothing in this policy alters an Employee's status and shall not constitute nor be deemed a contract or promise of employment. Employees remain free to resign their employment at any time for any or no reason without notice.

Bella Home Care Service LLC reserves the right to test Employees at any time. Refusal to take a drug test is grounds for termination. A failed drug test may be taken without recourse but will be unscheduled. Some Clients may require a drug test as a condition of badging or other activity. Refusal of such testing would be grounds for dismissal.

I have read, understand, and will comply with Bella Home Care Service LLC. Drug and Alcohol Free Workplace Environment Policy.

Date_____Applicant Signature_____

Print Name_____

EMPLOYEE COMMITMENT

Human Resources department and the administration of Bella Home Care are requiring if for any reason you decide not to continue to provide the services for the patient to give us minimum one week notice.

_____

Print Name:

_____ _____

Employee Signature Date

NON-COMPETE AGREEMENT

As an employee of Bella Home Care Services, LLC, the employee acknowledges that they will be in receipt of confidential information. This information shall include but not be limited to, procedures manuals, in-house policies, patient lists, patient's medical records, financial information and billing records, certifications and applications, actual and prospective markets an patient's, business plans and marketing strategies, customer lists, sales and marketing data, operating systems, income statements, asset and liability information, financial projections and any other confidential information gathered, revealed, acquired or generated by or for Bella Home Care Services, LLC Each employee shall protect and hold in confidence the confidential information to anyone except with the express written consent of M. Hussein). The employee acknowledges and understands the competitive sensitivity of the confidential information and the potential for significant material harm that could result to Bella Home Care Services, LLC in the event that confidential information is disseminated to others, in particular competitors. Therefore, the employee agrees that the appropriate remedy would be an immediate injunction against the violating employee in joining and prohibiting the use and continued dissemination of the confidential information. Further, each employee agrees that the dissemination of the confidential information would cause damages for which damages could not be readily ascertained and would constitute a breach of duty owed by the employee to Bella Home Care Services, LLC Each employee agrees to pay Bella Home Care Services, LLC in any action to enforce this confidentiality agreement or cost of litigation, including attorney's fees and other damages found by the Trier of fact.

As consideration for employment and for the release of this confidential information, employee agrees not to compete against Bella Home Care Services, LLC or to utilize any of the confidential information for a period of two (2) years from the date of their employment terminated with Bella Home Care Services, LLC This Non-Compete Agreement shall be limited to (Virginia) and contiguous counties. This Non-Compete Agreement is not intended to prohibit employee from working as a nurse, therapist or other position in the health service industries but is intended to prohibit employee from working with a competitor of Bella Home Care Services, LLCin the home health industry and utilizing any of the confidential information of Bella Home Care Service, LLC or contacting any of Bella Home Care Services, LLC patients. Employee agrees and warrants that they will not contact, engage, discuss, negotiate or contract with any patient or family member of a patient for those purpose of developing or promoting home health care services of said patient. All parties acknowledge that this confidential information is of a proprietary nature to Bella Home Care Service LLC and if the confidential information was revealed to the general public or to a competitor, the revelation would destroy or impair the expected success of Bella Home Care Service, LLC

*** ANY CONTROVERSY OR CLAIM ARISING OUR OF OR RELATING TO THIS AGREEMENT SHALL BE SUBMITTED TO ARBITRATION BEFORE ONE (1) ARBITRATOR IN (Virginia), IN ACCORDANCE WITH THE COMMERCIAL ARBITRATION RULES OF THE AMERICAN ARBITRATION ASSOCIATION JUDGEMENT UPON THE AWARD RENDERED BY THE ARBITRATOR MAY BE ENTERED BY ANY COURT HAVING JURISDICATION THEREOF. ARBITRATION SHALL BE THE EXCLUSIVE, FINAL AND BINDING METHOD OF RESOLUTION OF ANY CLAIM OR CONTROVERSEY BETWEEN Bella Home Care Service, LLC AND EMPLOYEE ARISING FROM THIS AGREEMENT.**

I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.

Employee Name _____ ***Date***----------

Agency Representative_____ ***Date***----------

SWORN STATEMENT OR AFFIRMATION

Please Print

Last Name	First	Middle	Maiden	Social Security Number

Current Mailing Address	Street, P.O. Box, Apt. #	City	State	Zip Code

Name of Church	Street, P.O. Box	City	State	Zip Code

1. Have you ever been convicted of or are you the subject of pending charges of any crime within the Commonwealth of Virginia or equivalent offense outside Virginia?

☐ Yes (convicted in Virginia) ☐ Yes (pending in Virginia) ☐ No

If yes, or pending, specify crime(s): _____

☐ Yes (convicted outside Virginia) ☐ Yes (pending outside Virginia) ☐ No

If yes, or pending, specify crime(s) and state, or other location:

---

2. Have you ever been the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth of Virginia?

☐ Yes (in Virginia) ☐ No (in Virginia)

☐ Yes (outside Virginia) ☐ No (outside Virginia)

If yes or pending, specify state, or other location: _____

I hereby affirm that the information provided on this form is true and complete. I understand that the information is subject to verification.

Signature Date

8989 Cotswold Dr Suite 7 Burke VA 22015
Tell: 703 323-4912 Fax: 323-4914
Email: info@bellahomecare.com

Re: EVV & Payroll Processing Rules

To Bella Home Care Employees:

The Bella Home Care payroll process is one that requires all employees to clock in and out on Location of patients home with EVV. A weekly signature of the the patient is required to complete the week. Without doing so Payroll is not able to be completed.

I _____ have read and fully understand the evv and payroll process. I do not have any questions about the process.

If I have any questions or concerns in the future, I will contact the BHC office with the numbers listed above.

_____

Employee signature Date

EMPLOYMENT REFERENCE CONTACT FORM

(Contact current employer only with permission of applicant)

(I give permission for Bella Home Service, LLC. to contact previous employers for information about me).

Applicant's Name: _____Signature: _____

Reference#1: Organization: _____ Applicant's position: _____

Employment Dates: From: _____ To: _____ Applicant's Manager/Supervisor: _____

Person contacted: _____ Relationship to applicant: _____

- Does the applicant's strong points on the job? What characteristics do you most admire about the applicant?
  _____
  _____
- How well does the applicant relate to other people? (superiors, peers, subordinates, other) _____
  _____
- Did the applicant exhibit professional behavior while working for you (i.e. conduct, discretion, punctuality, appearance, skills, etc.)? _____
  _____
- Are there any weaknesses or problems of which we should be aware? _____
  _____
- *Would you hire the applicant again? _____
  _____
- Is there anything else I should know about the applicant? _____
  _____

Reference#2: Organization: _____ Applicant's position: _____

Employment Dates: From: _____ To: _____ Applicant's Manager/Supervisor: _____

Person contacted: _____ Relationship to applicant: _____

- Does the applicant's strong points on the job? What characteristics do you most admire about the applicant?
  _____
  _____
- How well does the applicant relate to other people? (superiors, peers, subordinates, other) _____
  _____
- Did the applicant exhibit professional behavior while working for you (i.e. conduct, discretion, punctuality, appearance, skills, etc.)? _____
  _____
- Are there any weaknesses or problems of which we should be aware? _____
  _____
- *Would you hire the applicant again? _____
  _____
- Is there anything else I should know about the applicant? _____
  _____

Emergency Contact Person/Number/Relationship _____ Tel:(____)_____

Additional Comment: _____
_____

Completed by _____

Date First Reference Information obtained. _____ Date of second Reference information obtained. _____

Bella Home Service, LLC.
8989 Cotswold Dr. Ste 7 Burke, VA 22015
Tel. 703-323-4912 or 703-323-4914

Hygiene and Infection

Control advice in the home

Preventing infection in the home keeping your hands clean is the best way of preventing infection spreading in the home or the hospital. Your hands can pass an infection on and can pick up germs from one place and transfer them to another. We know that a toilet is full of germs but the germs can only move from the bathroom to the kitchen counter on our hands. Washing your hands with warm water and soap (preferably liquid soap)and drying them properly (with a paper towel) will remove germs and prevent them from moving anywhere else. Alcohol hand-rubs are useful in the home but they will not kill some germs, especially germs that cause diarrhea. Washing your hands properly at the bathroom sink is always the best way to get rid of germs. (You need to remember that the bathroom hand towel can spread germs.)You need to wash your hands

When to wash your hands:

*If your hands are dirty

*If you have been in contact with blood or body fluids (feces, vomit, spit, nappies, pads, pus and urine)

*If you use the toilet

*Before and after you touch a sick person

*Before you eat

*Before you prepare food

*After you have touched raw meat

*After you have cleaned your house

*After you feed or touch pets

*After any farming or gardening

*After you handle waste or rubbish

*After you wash soiled clothes

*After you cough or sneeze

Important: You should always cover cuts with waterproof plasters. You should also use hand cream to prevent cracks and breaks in the skin. This will help stop germs getting into the skin.

8989 Cotswold Dr., Burke, VA 22015 ♦ Tel: 703-323-4912 Fax: 703-323-4914
url: www.bellahomecare.com ♦ e-mail: info@bellahomecare.com

PERSONAL REFERENCE FORM

Reference for: _____

Name: _____

1. How long have you known the applicant?
   a. Personally: _____
   b. Professionally: _____

2. What has been your professional relationship with the applicant?
   ___Employer
   ___Coworker
   ___Supervisor
   ___Other, please specify _____

3. Please indicate your appraisal of the applicant in the following categories:

   a. Personal Honesty _____
   b. Personal Integrity _____
   c. Personal Ethics _____

4. Do you know of any instances where the applicant was convicted of illegal conduct or professional misconduct?
5. Additional information and comments which would amplify or clarify the items above and thus assist the Board in evaluating the applicant's experience and qualifications are strongly requested. Is there anything else you would like to add?

   _____
   _____
   _____
   _____
   _____

Interviewed By: _____

Date Interviewed: _____

8989 Cotswold Dr., Burke, VA 22015 ♦ Tel: 703-323-4912 Fax: 703-323-4914
url: www.bellahomecare.com ♦ e-mail: info@bellahomecare.com

8989 Cotswold Dr Suite 7
Tel. 703-323-4912Fax 703-323-4914

Personal Reference Form

Reference For: _____

Name: _____

1. How long have you know the applicant?
a. Personally:_____
b. Professionally:_____

2. What has been your professional relationship with the applicant?
__ Employer
__ Coworker
__ Supervisor
__ Other, please Specify_____

3. Please indicate your appraisal of the applicant in the following categories:

a. Personal Honesty _____
b. Personal Integrity _____
c. Personal Ethics _____

4. Do you know of any instances where the applicant was convicted of illegal conduct or professional misconduct?
5. Additional information and comments which would amplify or clarify the items above and thus assist the Board in evaluating the applicant's experience and qualifications are strongly requested. Is there anything else you would like to add?

_____
_____
_____
_____
_____

Interviewed By: _____

Date Interviewed:_____

8989 Cotswold Dr. Suit 7
Burke, VA 22015
Tel: 703-323-4912
Fax: 703-323-4914

RE: Registered Nurse Contract Agreement

This contract Agreement, is made effective as If (date)_____by and between Bella Home Care service, LLC and _____.

Bella Home Care Services shall contract you as a certified Registered Nurse to perform nursing practices that is required by Bella Home Care Service, LLC. In this agreement the nurse agrees to receive work requests and perform required assessment practices on a case by case basis. Range of work hours extends flexible to nurse to schedule and completion of assessment should correspond with Bella Home Care's reasonable time frame. Nurse agrees to upon completion of assessment, report accurate hours.

Bella Home Care shall compensate $50.00(for routine visits) per case ($80.00 for initial visits), paid bi-weekly, and reporting pay type as 1099. The contractor may terminate this agreement with a 2 weeks' notice minimum.

Welcome, and thanks for partnering with Bella Home Care Service, LLC to assist in providing excellent services to the health care client community.

_____ _____ _____ _____

Signature/ Musadaq Hussein (President) Date Signature: Registered Nurse Date

Bella Home Care Service, Representative

THE CULTURAL SENSITIVITY AND AWARENESS CHECKLIST

1. Communication method: Identify the patient's preferred method of communication. Make necessary arrangements if translators are needed.

Miscommunication occurs frequently between health care professionals and patients,14 a problem that is intensified by language barriers. About 14% of the USA population do not speak English at home.15 Of the people who speak a language other than English at home, 47% say they have difficulty speaking English.16 Assuring information is conveyed and received as intended must consistently be a top priority. Translators are commonly utilised in the health care profession. A potential problem associated with use of translators is, " . . . that respondents often experienced communication as one-way rather than two-way".17 Care should be taken to compensate for this effect. The Brain Injury Rehabilitation Service (BIRS) recommends " . . . a continual two-way process of sharing information, hopes and fears. It involves the continual checking of how the other person has heard or understood what has been said."17 Considering dialects in addition to basic language types whenever possible is essential. Understanding "a little" is not adequate for communication as important as that which occurs in medical settings.

2. Language barriers: Identify potential language barriers (verbal and nonverbal). List possible compensations.

Non-verbal communication plays an essential role when people are exchanging information.18 Like the old adage indicates: you cannot, not communicate. Communication experts routinely emphasise the significance of understanding the intricacies of non-verbal communication. Most of what we understand is conveyed by non-verbal cues—it is not what we say but how we say it. All of us use these cues to aid clarification during complicated situations. We should all learn how we convey information non-verbally to avoid expressing personal biases.

3. Cultural identification: Identify the patient's culture. Contact your organisation's culturally specific support team (CSST) for assistance.

If your organization does not already have one, form a culturally specific support team. The CSST is composed of people who are able to represent various cultures and ethnic groups, preferably people who are actually members of the specific groups. This is not always possible, and when it is not, the next best thing is to have someone who is familiar with and sensitive to the culture or ethnic group and its customs. This group's role is to help educate caregivers about the target culture's customs and possible associated needs that will play a role in recovery. For example, a culture's beliefs about modesty and dress may need to be addressed throughout the recovery process. Many Asian and Muslim women may feel uncomfortable wearing hospital attire.19 The CSST can assist health care professionals in finding alternative ways to respect people's modesty and cultural beliefs. The CSST also helps to ensure

understanding in essential interactions with patients and families. The CSST collects and provides information about community resources that might be useful for a particular culture or ethnic group's needs. Translators are usually an integral part of this team. Education is another important CSST role. Education can help reduce prejudice that could interfere with optimum health care. Remember to consider potential healing practices such as curanderismo and ethnic healing ceremonies when appropriate.

4. Comprehension: Double-check: Does the patient and/or family comprehend the situation at hand?

Remember, nodding and indicating some type of affirmative response does not necessarily guarantee understanding has been achieved. Re-explaining is useful and facilitates comprehension, particularly during times of stress. Effective communication launches effective care. One useful technique is to gently ask the patient or family member to convey the information, in his/her own words, before concluding that he/she understands.20

5. Beliefs: Identify religious/spiritual beliefs. Make appropriate support contacts.

Religious/spiritual beliefs play an important and powerful role in recovery. We found in our study of superior recovery that religion/spirituality is one of the characteristics that contributes to a successful recovery.21 Patients and families often attribute successful recovery, as well as survival, to these types of beliefs.22 Contact community resources appropriate for the identified belief system.

6. Trust: Double-check: Does the patient and/or family appear to trust the caregivers? Remember to watch for both verbal and non-verbal cues. If not, seek advice from the CSST.

A study by the brain injury rehabilitation unit (BIRU) at Liverpool Hospital in Australia found that “good communication leading to the establishment of trust”17 seemed to be more important to the participants than the expertise of the professional. “A good professional is one you can trust.”17 Lack of trust can impede achieving the best possible outcomes because the patient and family might withhold essential health-related information. Another trust-related impediment occurs when patients and families fail to follow crucial instructions or do not believe recovery can be achieved.

7. Recovery: Double-check: Does the patient and/or family have misconceptions or unrealistic views about the caregivers, treatment, or recovery process? Make necessary adjustments.

Give those involved enough time to process information received and to gain familiarity with the situation. Later, allow more time to for any questions that will help clarify the circumstances. Patients and their families routinely experience misconceptions or form unrealistic expectations that can impair the ability to make the wisest decisions. Help guide appropriate conceptions.

8. Diet: Address culture-specific dietary considerations.

Certain cultures and ethnic groups include very specific dietary regulations. As nutritionists have long stressed, appropriate nutrition is vital to optimum recovery. Simple dietary modifications can be made that will respond to these needs. As an added bonus, this action will convey respect for the particular culture or ethnic group, thus raising comfort level and trust.

9. Assessments: Conduct assessments with cultural sensitivity in mind. Watch for inaccuracies.

Be aware of potential differences in culturally accepted emotional expression and verbalisations of private information. For cognitive assessments, tests must be analysed to identify culturally specific questions and modified accordingly. Even subtle differences can profoundly influence assessments. Ask the CSST to review both medical and cognitive assessment practices.

10. Health care provider bias: We have biases and prejudices. Examine and recognise yours.

It is a fact of life that prejudice and bias exist. Those who deny it are most afflicted. Identifying and recognising this will help control its expression. To accomplish cultural awareness effectively “the health care professional must first understand his or her own cultural background and explore possible biases or prejudices toward other cultures”.23 Upon close examination of prejudice, bias, and their sources, it appears that fear is the foundation. Work to overcome these fears; education will facilitate the process.

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					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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