

Humane Home Care Face to Face Interview Questions

1. Please tell me about your home care experience.
2. What training have you received? Are you CPR certified?
3. Do you have your own car and personal auto insurance?
4. Are you flexible with your schedule, or do you need a set number of days and hours to work?
5. Do you understand universal precautions, and what does that mean to you?
6. Do you understand that you are a “guest” in the client’s home, and what does that mean to you?

Do you have any difficulty turning in your work on time?

7. Do you understand that aides **cannot** administer medications and explain to me why aides are not permitted to give meds?

8. What are some of the hobbies you enjoy in your spare time?

9. Will there be any personal issues that will keep you from meeting your required weekly schedule?

10. Have you lived in Pennsylvania for the past two years?

COMMENT SECTION BY INTERVIEWER:

Candidate _____ Date _____

Agency Representative _____ Date _____

HUMANE HOME CARE AGENCY, LLC.
2615 Philmont Ave, HUNTINGDON Valley PA, 19006
Office: 215-947-1988 Fax: 215-947-1999

**INDUSTRIAL HEALTH CARE CENTER
WORKERS' COMPENSATION PANEL**

The Pennsylvania Workers' Compensation Act provides disability and medical benefits to an employee who incurs any injury arising in the course of his/her employment and related thereto. In the event of such an injury, you may promptly report it to your supervisor and complete an Employee Accident Report Form. Should you need medical attention during the first (90) days, you are to receive it only from the list of approved centers and doctors below. We will not honor medical bills submitted from any center or hospital not on the approved list below. After (90) days of treatment, you may select any health care provider of your choice. However, you must advise your supervisor within 5 days of the first visit to each and every non- designated provider not listed below. Failure to do so may affect whether we are liable for payment rendered prior to appropriate notice. Should you have any questions, please see your supervisor.

Thank you for your cooperation.

ALWAYS CONTACT IHCC FIRST

ALL INJURIES - GENERAL PRACTITIONER: INDUSTRIAL

HEALTH CARE CENTER (IHCC)

2804 SOUTHAMPTON RD., PHILA. PA. 19154 215-677-0930

OCCUPATIONAL MEDICINE

IHCC

2804 Southampton Rd

Phila, Pa 19154

HOSPITAL

Nazareth Hospital

2601 Holmes Ave

Phila, Pa 19152 Phila, Pa 19115 215-677-0930

DERMATOLOGY

Harold Farber

9892 Bustleton Ave.

215-335-6000 215-676-2464

OPHTHALMOLOGIST ORTHOPEDICS

Dennis Khoury MD

M. Shayegan MD

8118 Bustleton Ave

Phila, Pa

215-342-8118

Rothman Institute

2630 Holme Ave

2nd Floor

Phila., Pa 19152

215-992-4960

Cautilli M.D.

115 Floral Vale Ste C

Yardley, Pa 19067

215-504-6101

215-725-4999 fax

GENERAL SURGERY

Surgical Specialist Group

Bustleton Ave, Ste 206

Phila, Pa 19115

215-673-0343

NEUROSURGERY

Temple University Hosp.

3402 North Broad St

Phila, Pa 19152

215-707-4067

NEUROLOGIST

Katz, Bennet, Levin MD

Bustleton Ave

Ste 306

Phila., Pa 19115 215-324-3300

PLASTICS/HAND

George Zavitsanos IVMD: Ste 210 Frankford Medical Office,

Frankford Torresdale Hospital

Phila., Pa 19114 215-641-2300 fax: 215-628-2411

PHYSICAL THERAPY

CENTER REHAB & FITNESS

SOUTHAMPTON RD

PHILA, PA 19154 215-677-0930

Signature

Date:

Humane Home Care Agency
2615 Philmont Ave, HUNTINGDON Valley PA, 19006
Office: 215-947-1988 Fax: 215-947-1999

HBV VACCINE / WAIVER FORM

Employee Name: _____ **Date of Hire:** _____
Print Name

Social Security Number: _____

I understand that due to my occupational exposure to blood or other potential infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) Infection. **I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself.** I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

I have been advised of my rights to accept or decline the HBV Vaccine. HBV (Hepatitis B Virus) has been fully explained to me.

_____ **I choose to waive my rights to receive the HBV Vaccine**

_____ **I choose to receive the HBV Vaccine and I understand that the vaccine is given in a 3-part series.**

Series # 1 Date	Series # 2 Date	Series # 3 Date

Employee Signature

Date

Agency Rep. Signature

Date

Humane Home Care

Home Health Aide Skills Checklist

Home Health Aide: _____

Home Health Aid Self Rating

Competency Assessment Method

A = I can perform well	D = Direct Observation and/or Demonstration
B = I need to review	O = Oral Question and Answer
C = I have no experience	(Circle the appropriate method below)

Skills	Self Rating	Supervisor Assessment Method	Supervisor Evaluation	
			Competency	Supervisor Initials & Date
Communication	A, B, or C	D or O	☐ Met ☐ Not Met	
Observation, reporting and documentation of patient status and the care of services provided	A, B, or C	D or O	☐ Met ☐ Not Met	
Universal Precautions	A, B, or C	D or O	☐ Me ☐ Not Met	
Basic elements of body functions and changes in condition that must be reported	A, B, or C	D or O	☐ Met ☐ Not Met	
Maintaining a clean, safe and health environment	A, B, or C	D or O	☐ Met ☐ Not Met	
Ability to recognize emergency situations	A, B, or C	D or O	☐ Met ☐ Not Met	
Ability to recognize physical and emotional needs and work with the client and respect the pt.'s privacy and property	A, B, or C	D or O	☐ Met ☐ Not Met	
Appropriate and safe techniques in personal hygiene and grooming:				
Bed Bath	A, B, or C	D or O	☐ Met ☐ Not Met	
Sponge Bath	A, B, or C	D or O	☐ Met ☐ Not Met	
Shampoo (sink, tub or bed)	A, B, or C	D or O	☐ Met ☐ Not Met	
Nail Care	A, B, or C	D or O	☐ Met ☐ Not Met	
Skin Care	A, B, or C	D or O	☐ Met ☐ Not Met	
Oral Hygiene	A, B, or C	D or O	☐ Met ☐ Not Met	

Toileting and elimination	A, B, or C	D or O	☐ Met ☐ Not Met	
Safe transfer techniques	A, B, or C	D or O	☐ Met ☐ Not Met	
Safe Ambulation	A, B, or C	D or O	☐ Met ☐ Not Met	
Normal positioning with proper body alignment	A, B, or C	D or O	☐ Met ☐ Not Met	
Ability to recognize adequate nutrition and intake	A, B, or C	D or O	☐ Met ☐ Not Met	
Other:	A, B, or C	D or O	☐ Met ☐ Not Met	

Employee Signature: _____

Date: ____/____/____

Agency Rep. Signature: _____

Date: ____/____/____

Note: Clearance results will be mailed to you within 14 days from the date that the clearance is received in our office. Failure to comply with the above instructions will cause considerable delay in processing the results of an applicant's child abuse clearance.
CLGS-32-6 (8-11)



RESIDENCY CERTIFICATION FORM

Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS (No PO Box, RD or RR)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE 		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION - EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	WORK LOCATION PSD CODE 		WORK LOCATION NON-RESIDENT EIT RATE

CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE		DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS	

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com

Direct Deposit Authorization

1. Employer Information

Company Name	Company Number
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2. Employee Information

Last Name	First Name	MI
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Employee Identification Number

3. Bank Information *

Bank Name	Account Type
	Checking Savings

Routing/Transit Number. <i>These are the nine digits to the left of your account number on the bottom of your check (must begin with 0, 1, 2, or 3).</i>

Account Number

Amount to be deposited <i>(Select either percentage or dollar amount.)</i>
Percentage. Please specify: % Dollar amount. Please specify: \$

4. Additional Bank Information *

Bank Name	Account Type
	Checking Savings

Routing/Transit Number. <i>These are the nine digits to the left of your account number on the bottom of your check (must begin with 0, 1, 2, or 3).</i>

Account Number

Amount to be deposited <i>(Select either percentage or dollar amount.)</i>
Percentage. Please specify: % Dollar amount. Please specify: \$

5. Authorization Agreement for Direct Deposit

*Please note, it can take one to two payroll periods to process your direct deposit request and for you to begin receiving direct deposits.

I authorize my employer to make deposits to my account. In the unlikely event of a deposit error, I authorize my employer to make adjustments to correct the error.

Signature	Date
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*Attach a voided check with this agreement. Deposit slips are not accepted. Information provided should

**Humane Home Care Agency
Tuberculosis (TB) Risk Assessment Questionnaire**

First Name: _____ Last Name: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Date of Birth: _____

1. Are you from or have you lived for two months or more in Africa, Asia, Central or South America, or Eastern Europe? ☐ Yes ☐ No If yes, list countries _____

2. Have you been diagnosed with a chronic condition that may impair your immune system?
☐ Yes ☐ No If yes, check all that apply

☐ Chronic steroid use	☐ Gastrectomy/intestinal bypass	☐ Diabetes mellitus
☐ HIV infection	☐ Crohn's disease	☐ Dialysis/Renal failure
☐ Cancer of the head or neck	☐ Rheumatoid arthritis	☐ Chronic malabsorption syndromes
☐ Silicosis	☐ Use of a TNF- α antagonist	☐ Low body weight (10%+ below ideal)
☐ Leukemia, lymphoma or Hodgkin's disease	☐ Other: _____	

3. Have you ever resided, worked or volunteered in any of the following facilities?
☐ Yes ☐ No If yes, check all that apply

☐ Prison	☐ Hospital	☐ Nursing home
☐ Homeless shelter	☐ Other long term treatment center: _____	

4. Do you currently have any of the following symptoms? ☐ Yes ☐ No If yes, check all that apply

☐ Cough $\geq$ 3 weeks	☐ Unexplained fever	☐ Chest pain	☐ Chills
☐ Productive cough	☐ Night sweats	☐ Respiratory difficulty	☐ Loss of appetite
☐ Coughing up blood	☐ Unexplained weight loss	☐ Fatigue	☐ Weakness

5. Have you ever had contact with a person known to have active tuberculosis? ☐ Yes ☐ No

6. Have you ever used injection drugs? ☐ Yes ☐ No

7. When was your last tuberculin skin test or chest x-ray to rule out TB? (attach results)

Date: _____ Where given: _____

The information above is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

Signature of Humane HomeCare Agency Employee _____ Date _____

All information below is to be completed by an approved screener

Findings (Check all that apply)

☐ Previous Treatment for TB disease	☐ No risk factors for TB infection	☐ Previous positive TST, no prior treatment
☐ Possible TB suspect	☐ Risk(s) for infection and/or progression to disease	

Actions (Check all that apply)

☐ Issued screening letter	☐ Referred for CXR	☐ Referred for medical evaluation
☐ Issued Sputum containers	☐ Administered Mantoux TB Test	☐ Other: _____

Signature of Screener _____ Date _____

Printed Name and Title of Screener _____

Humane HomeCare Agency, LLC
 2615 Philmont Ave, HUNTINGDON Valley PA, 19006
 Telephone (215) 947-1988

Application for Employment

We are an equal opportunity employer who provides equal access to programs, services and employment to all people. All qualified applicants will receive equal consideration for employment without regard to race, color, national origin, religion, sex, marital status, sexual orientation, age, physical or mental disability, or covered veteran status. Those applicants requiring reasonable accommodation for the application and/or interview process should notify Humane Home Care Agency, LLC.

Personal Information							
Last Name			First		M.I.	DOB:	
Street Address					Apartment/Unit #		
City				State		ZIP	
Phone		E-mail Address				Race:	
Date Available			Social Security No.		Gender:		
Position Specific Information							
Position Applied For:							
☐ CNA Registration # _____		☐ Direct Care Worker					
☐ Other:							
Has your license ever been suspended or revoked? ☐ YES ☐ NO If yes, explain							
☐ Part Time ☐ Full Time ☐ Live-In 12-Hour Shifts: ☐ AM ☐ PM							
Time Availability: (check all times you are available for work; times noted are approximate)							
Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8 am to 12							
12 pm to 4							
4 pm to 8							
8 pm to 12							
12 am to 4							
4 am to 8							
Are you a citizen of the United States? ☐ YES ☐ NO If no, are you authorized to work in the U.S.? ☐ YES ☐ NO							
Have you ever worked for this company? ☐ YES ☐ NO If so, when?							

Have you ever been convicted of a felony or misdemeanor?	☐ YES	☐ NO	If yes, detail		
Languages Spoken	☐ Spanish	☐ French	☐ Russian	☐ Vietnamese	☐ Korean

Education					
High School		Address			
From	To	Did you graduate?	☐ YES	☐ NO	Degree
College		Address			
From	To	Did you graduate?	☐ YES	☐ NO	Degree
Other		Address			
From	To	Did you graduate?	☐ YES	☐ NO	Degree

Please List Three Professional References:	
Full Name	Relationship
Company	Phone ()
Address	
Full Name	Relationship
Company	Phone ()
Address	
Full Name	Relationship
Company	Phone ()
Address	

Previous Employment			
Company		Phone ()	
Address		Supervisor	
Job Title	Starting Salary	\$	Ending Salary \$
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference?			
☐ YES ☐ NO			

Company		Phone ()	
Address		Supervisor	
Job Title	Starting Salary \$	Ending Salary \$	
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? ☐ YES ☐ NO			
Previous Employment, Continued			
Company		Phone ()	
Address		Supervisor	
Job Title	Starting Salary \$	Ending Salary \$	
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? ☐ YES ☐ NO			
Emergency Contact			
Name		Phone	
Address		Relationship	
Email:			

Employment Application Disclosure and Authority to Release Information PLEASE READ THIS STATEMENT CAREFULLY BEFORE SIGNING. I understand that in processing my application with Humane Home Care Agency a background check will be conducted. Information may include, but is not limited to employment history, education, criminal records, national sex offender check, child abuse clearance, motor vehicle records, personal references and any data provided on this application or during the interview process. If currently employed: My current employer may be contacted YES ☐ NO ☐ I authorize the appropriate individuals, companies, institutions or agencies to release information and I release them from any liability because of such inquiries or disclosures. I have read, understand, and by my signature, consent to these statements. I hereby certify that all the statements and answers set forth on the application form, my resume and interview are true and complete to the best of my knowledge. If this application leads to employment, I understand that if any statements and/or
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answers are found false or the information has been omitted, such false statements or omissions may be cause for rejection of my application or termination of my employment.

Legal Last Name: _____ Legal First Name: _____

Legal Middle Name _____

Street Address:

City: _____ State: _____

Zip Code: _____

Please list any additional addresses where you have lived, worked and attended schools during the past 7 yrs.

Street: _____

City: _____ State: _____

Street: _____

City: _____ State: _____

Street: _____

City: _____ State: _____

Street: _____

City: _____ State: _____

Street: _____

City: _____ State: _____

Street: _____
City: _____ State: _____

Other Name(s) Used and Date(s) Changed:

Driver's License Number: _____ State Issued: _____ Expiration Date: _____

Social Security Number: _____ Date of Birth: _____

I authorize a photocopy of this release to be accepted with the same authority as the original, and if employed by Humane Home Care Agency, this release will remain in effect throughout such employment.

Signature: _____ Date: _____

Please RETURN to:
Humane HomeCare Agency, LLC
2615 Philmont Ave, HUNTINGDON Valley PA, 19006

HIRE WILL BE PROVISIONAL UNTIL REQUIREMENTS CLEAR

Dear _____

This is to confirm that the offer of employment extended to you as a Direct Care Worker at Humane Home Care Agency is conditional on successful completion of a criminal background check.

A criminal background check will be ran in the office and typically receives results the same day. However, if the result is under review; a report will be received from the Police Department in approximately 30 days.

If the check reveals no criminal convictions relevant to the position, the office staff will inform you that you have been cleared for employment in the position. If the check reveals a criminal conviction, and the conviction is listed on the Prohibited Offense list from the State, the Agency cannot offer a permanent employment as a Direct Care Worker. The agency will provide you with a summary of your criminal background check results, regardless of the outcome, we will inform you when a conviction disqualifies you from employment in a sensitive position.

All new employees MUST complete their Physical Examination and Two-Step PPD/Chest X-ray before they can start employment.

Humane Home Care Agency also requires for employees to get a drug test, a set of trainings, a competency test and child abuse clearance. All these would have to be completed within 30 days in order to be offered permanent employment. However, if one of these requirements is not completed, there will be no employment offer.

Applicant Signature _____ Date _____

Supervisor Signature _____ Date _____

Thank you,

Mark Tay, CEO

HUMANE HOME CARE AGENCY

2615 Philmont Ave, HUNTINGDON Valley PA, 19006

Office: 215-947-1988 Fax: 215-947-1999

Employment Physical Exam/Medical History

Name: _____ SSN: _____

Employee Position Applied For: _____

Phone Number : _____ Birth Date: _____

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As a condition for employment with Humane Home Care Agency you must successfully complete a physical examination to determine that you are in good health, free of communicable diseases and tuberculosis. In addition, your physical must provide the results of your TB skin test or chest x-ray, as well as the date on which it is performed, and read, within the last 90 days.

TO BE COMPLETED BY PENNSYLVANIA LICENSED PHYSICIAN OR NURSE PRACTITIONER

Date of Examination: _____ General Appearance: _____

Height: _____ Weight: _____ Allergies: _____ Temperature: _____

Pulse: _____ Respiration: _____ B/P: _____ Mantoux/PPD Test: Date Done: _____

Date Read: _____ Result: _____

2Step PPD: Montoux/PPD Test: Date Done _____ Date Read: _____ Result: _____

If positive, chest x-ray: Datedone: _____ Result: _____ Date TB Prophylaxis initiated: _____

NORMAL				
SYSTEM	NO	YES	IF ABNORMAL, COMMENTS:	
SKIN				
EYES				
EARS				
NOSE				

THROAT/DENTAL				
CARDIOVASCULAR				
RESPIRATORY				
GASTRO-INTESTINAL				
GENITO-URINARY				
NEUROLOGICAL				
MUSCULOSKELTAL				
OTHER				

Allergies: _____

Current Medication: _____

Imminization: _____

Mantoux/PPD: _____ MMR: _____ Chicken Pox: _____ Hep B: _____

Rabies: _____ Other: _____

Summary of Findings: _____

I hereby certify that I have examined the above applicant, they are free from all communicable disease and that the above is a complete and accurate record of my examination. I hereby state that this employee is in good physical and mental health which is required to perform the essential functions of the position of which he or she is applying:

License Number: _____

Print Name: _____

Signature: _____

Address: _____

Telephone: _____

Humane HomeCare Agency

RECEIPT OF EMPLOYEE HANDBOOK

Last Name

First Name

My signature on this form acknowledges that I have received a copy of the Humane HomeCare Agency Employee Handbook dated December 15, 2022. I understand that it is my responsibility to read the Handbook. If I have questions concerning the information herein, I will bring them to the attention of the Administrator.

I understand that the policies and procedures contained in the Handbook constitute guidelines only and are in no way to be interpreted as a contract between Humane HomeCare Agency and any of its employees. I further understand that Humane HomeCare Agency has the right to change, modify, or delete any of its work rules and policies at any time.

Employee Signature

Date

Witness Signature

Date