Ark Home Health Care
Pediatric/Adult Services
An act of random kindness 1240 Southridge Court #106, Hurst Texas Ph: (817) 952-3093 • Fx: (817) 952-3095

GREETINGS,

We are so excited about your interest in becoming a part of a great team of caregivers.

In an attempt to prevent delays in your hiring process, please have the following items with you:

Drivers License
Social Security Card
Car Insurance
Diploma, Transcript or Certificate of Completion
Current CPR Card *(You may contact Gerald@**214-912-2146** for scheduling, if expired)*
*****CPR TRAINING MUST BE A HANDS ON CLASS-NO ONLINE TRAINING ACCEPTED*****

All items must be provided before we are able to schedule you with a client.

Thank you for your time and we look forward to making you a part of our team.

Sincerely,
Ark Home Health Care

PLEASE KEEP THIS DOCUMENT
DO NOT TURN IN WITH YOUR APPLICATION

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APPLICATION FOR EMPLOYMENT

All prospective employees will receive consideration without discrimination because of race, color, creed, age, natural origin or handicap. All information provided herein will be kept confidential.

PERSONAL INFORMATION:

Last Name **First** **Middle** **Date**

Street Address **Home Phone**

City, State, Zip Code **Cell Phone**

S.S. # **Date of Birth**

Email Address ******This email will be used for your direct deposit so please print clearly******

Emergency contact name:_____

Emergency contact number:_____

Are you 18 years of age or older? ◉ YES ○ NO

Are you seeking: ☐ FULL-TIME ☐ PART-TIME ☐ OTHER_____

Wage or Salary Desired: $_____

Have you ever applied for employment with this Agency? ○ Yes ◉ No

How many hours a week are you available for work? _____

Are you legally eligible for employment in the United States? ◉ Yes ○ No

How did you learn of our organization? ☐ Newspaper Ad ☐ Agency employee ☐ Other

Are you willing to work: ☐ Evenings ☐ Weekends ☐ Holidays ☐ Rotating Shifts

When can you start? _____

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Have you ever been convicted of a felony? ◯ YES ◉ NO
If yes, please explain:

_____

_____

_____

Please note that prior to employment, this facility is required by Texas law to perform a criminal conviction check on all unlicensed personnel, and is prohibited from permanently employing any person whose check reveals certain past criminal convictions.

Answer this question only after receiving description of the job applied for: Can you perform the essential function of this job with or without reasonable accommodations? ◉ YES ◯ NO If no, what can be done to accommodate your limitation?

_____

_____

_____

Position applying for: (Mark One) ☐ RN ☐ LVN ☐ HHA/CNA ☐ Therapist (Specify)
☐ Caregiver/Attendant ☐ Office Staff ☐ Other (Specify): _____

EDUCATION:

NAME AND LOCATION OF SCHOOL	MAJOR	DIPLOMA/DEGREE	DID YOU GRADUATE?
HIGH SCHOOL			◉ YES ◯ NO
COLLEGE/UNIVERSITY			◯ YES ◯ NO
COLLEGE/UNIVERSITY			◯ YES ◯ NO
OTHER TRAINING/EDUCATION			◯ YES ◯ NO
ARE YOU STILL IN SCHOOL? Circle One: YES NO If Yes, Where?			

PROFESSIONAL LICENSES AND/OR CERTIFICATIONS:

TYPE	ORGANIZATION OR STATE ISSUED	DATE ISSUED	NUMBER

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EMPLOYMENT:

ARE YOU CURRENTLY EMPLOYED? ◯ YES ◉ NO

MAY WE CONTACT YOUR PRESENT EMPLOYER? ◉ YES ◯ NO

CURRENT OR LAST EMPLOYER

NAME OF COMPANY SUPERVISOR TELEPHONE NUMBER

ADDRESS SALARY

POSITION AND DUTIES DATE STARTED – DATE LEFT

REASON FOR LEAVING

NAME OF COMPANY SUPERVISOR TELEPHONE NUMBER

ADDRESS SALARY

POSITION AND DUTIES DATE STARTED – DATE LEFT

REASON FOR LEAVING

NAME OF COMPANY SUPERVISOR TELEPHONE NUMBER

ADDRESS SALARY

POSITION AND DUTIES DATE STARTED – DATE LEFT

REASON FOR LEAVING

NAME OF COMPANY SUPERVISOR TELEPHONE NUMBER

ADDRESS SALARY

POSITION AND DUTIES DATE STARTED – DATE LEFT

REASON FOR LEAVING

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APPLICATION FOR EMPLOYMENT:

Was your last name different from your present name during the above listed jobs? ◯ YES ◉ NO

If yes, what was your name? _____

Are you currently employed? ◯ YES ◉ NO

Do you have reliable transportation? ◉ YES ◯ NO

PROFESSIONAL REFERENCES:

Persons who can furnish information about job performance

1. Name: _____ Telephone: _____
   Address: _____
2. Name: _____ Telephone: _____
   Address: _____
3. Name: _____ Telephone: _____
   Address: _____

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AUTHORIZATION TO RELEASE INFORMATION

I, _____ _____ _____
Last Name First Name Middle Name

_____ _____
Current Address Dates Lived Here

Addresses for the Past Seven Years: (include street, city, state, zip code) Dates of Residence:

_____ _____

_____ _____

_____ _____

_____ _____ _____
Date of Birth Other Names Used (including maiden name) Years Used

_____ _____ _____
Social Security Number Driver's License Number State

do hereby authorize verification of all information in my employment application from all sources of employment, education, motor vehicle, financial history, criminal history, personal character, & worker's compensation records in accordance with ADA, labor & wage records, etc. or any pare thereof, & authorize any duly authorized agent of Ark Home Health Care Services to obtain, whether the said records are public or private, & including those which may be deemed to be privileged or confidential in nature & I release all persons from liability on account of such disclosures. Information appearing on this Authorization will be used exclusively by Ark Home Health Services for identification purposes & for the release information which will be relied upon in considering my application for employment. I agree to provide additional information that may be requested to process my employment application. I authorize without reservation, any party or agency contacted by Ark Home Health Care Services to furnish the above-mentioned information. This authorization is valid during the course of my employment to the extent permitted by law.

**I hereby ◉ do ○ do not authorize you to contact *my current* employer for Employment & Reference Verifications (This will authorize immediate inquiries to the Human Resources Department & to any listed supervisors or references in the Employment/Reference Section of your application.)

I have the right to make a request to Ark Home Health Care Services, upon proper identification, to request the nature & substance of all information in its files on me at the time of my request, including sources of information, & the recipients of any reports on me which Ark Home Health Care Services has previously furnished within the two year period preceding my request.

I understand & agree that any omission, false statement, misleading statement, or answer made by me on my application or any supplements to it & in any interviews will be sufficient grounds for rejection of employment & my discharge after employment.

_____ _____ _____
Printed Name Applicant Signature Date

☐ **CALIFORNIA, OKLAHOMA, & MINNESOTA RESIDENTS ONLY: If you are a current California, Oklahoma, or Minnesota resident & would like to request a copy of our Consumer Report or Investigation Consumer Report, please check the box. This report may include character & reputation information obtained through personal interviews.**

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APPLICANT REFERENCE CHECK (1)

To Whom It May Concern,

The applicant named below has submitted an application for employment with Ark Home Health Care Pediatric Services, Inc. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name: _____ Date of Application: _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

I hereby authorize the following information to be released. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ To: _____

Position Held: _____

Is applicant eligible for Re-hire: ☐ YES ☐ NO

Additional comments : _____

_____

_____

Reference check performed by: _____ Date: _____

Reference check completed via: ☐ Phone ☐ Fax

Please fax to: 817-952-3095

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APPLICANT REFERENCE CHECK (2)

To Whom It May Concern,

The applicant named below has submitted an application for employment with Ark Home Health Care Pediatric Services, Inc. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name: _____ Date of Application: _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

I hereby authorize the following information to be released. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ To: _____

Position Held: _____

Is applicant eligible for Re-hire: ☐ YES ☐ NO

Additional comments : _____

_____

_____

Reference check performed by: _____ **Date:** _____

Reference check completed via: ☐ Phone ☐ Fax

Please fax to: 817-952-3095

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HEPATITIS VACCINE REQUIREMENT

I _____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

- ○ Request that I receive the Hepatitis vaccine
- ◉ Refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the 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 vaccine series at no charge to me.
- ○ Provide written proof of immunity (attach)
- ○ Provide written proof of previous vaccination (attach)
- ○ Provide written proof of medical contraindication (attach)

Signature: _____ Date: _____

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TB TARGETED MEDICAL QUESTIONNAIRE FORM

To be completed by employee:_____
(Print Name)

		YES	NO
1.	Have you ever had a positive TB skin test or history of TB infection? If the answer is YES, please answer the following:	○	○
2.	Have you ever had the BCG vaccine?	○	○
3.	Do you have prolonged or recurrent fever?	○	○
4.	Have you recently lost weight?	○	○
5.	Do you have a chronic cough?	○	○
6.	Do you cough up blood?	○	○
7.	Do you have sweating at night?	○	○

8. Do you have any of the following risk factors which may substantially Increase the risk of tuberculosis?

- ☐ a. Silicosis (Lung Disease)
- ☐ b. Gastrectomy
- ☐ c. Intestinal Bypass
- ☐ d. Weight 10% or more below ideal body weight?
- ☐ e. Chronic Renal Disease
- ☐ f. Diabetes Mellitus
- ☐ g. Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy
- ☐ h. Hematologic Disorder 1.e. leukemia or lymphoma
- ☐ i. Exposure to HIV or AIDS
- ☐ j. Other malignancies

_____ _____
Employee Signature Date

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APPLICATION FOR EMPLOYMENT

CREDENTIALS/SPECIALIZED SKILLS & QUALIFICATIONS/EQUIPMENT OPERATED

List all states in which licensed giving registration and expiration date. Summarize special job-related skills and qualification acquired from employment or other experience.

_____

_____

_____

_____

_____

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand, that, if employed, falsified statements on this application SHALL BE GROUNDS FOR DISMISSAL

I Authorize complete investigation of all statements contained herein and herby give my full permission for Ark Home Health Care to contact and fully discuss my background and history with all persons and entities listed above to give Ark Home Health Care any and all information concerning my previous employment and any information they may have, and release all former employees and others listed above from all liability for any damage that my result from furnishing the same to Ark Home Health Care.

I understand and agree that, if hired, my employment is for no definite period arid may, regardless of the date of payment of my wages and salary, be terminated at any time for any lawful reason, without prior notice and with or without cause.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period shall inquire as to whether or not applications are being accepted at that time.

DATE:_____ **SIGNATURE** _____

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CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

It is both the Agency's and the employee's responsibility to ensure that every patient's health information is protected at all times. By signing below you are indicating the acknowledgement of HIPAA and understand that a thorough orientation of the agency's policy regarding patient's Protected Health Information will be provided to you upon hire.
I understand that I may be handling Protected Health Information. I further understand that there are specific guidelines associated for use and disclosure of Protected Health Information. The agency has sanctions and fines for all individuals failing to comply with HIPAA Rule and Regulations.

Employee: _____ Date: _____

PROTECTION OF HEALTH INFORMATION

There are specific guidelines to ensure patient's Protected Health Information is kept private. I understand that my employment with the agency involves handling Protected Health Information. I will ensure patient's records are protected by enforcing the following measures:

- Patient Protected Health Information will be transported in a protected travel chart when traveling.

- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it is conducted in a private area.

- Patient Protected Health Information will be returned to the agency upon acknowledgement of the patient being discharged.

I pledge to make every effort to keep patient's Protected Health Information protected at all times.

Employee_____ Date:_____

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FIELD EMPLOYEE STANDARDS AND PROCEDURES

Welcome! Ark Home Health Care requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the patient/client/family. This includes personal hygiene, jewelry, hair and makeup.

2. **Please do not smoke in the presence of a patient/client.**

3. Always wear your ID Badge. Licensed personnel must always carry their current nursing license and CPR care while on assignment.

4. You are expected to arrive on time to all assignment that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more, or to be totally absent from the assignment you must notify the Agency immediately. PLEASE DO NOT CALL YOUR PATIENT DIRECTLY. You may call the Agency 24 hours a day if you need to cancel or reschedule your assignment. **A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!**

5. If you have any problem, incident or accident on the job, do not discuss it with the patient/client, but call the Agency immediately.

6. If the patient/client asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.

7. Paraprofessional personnel (i.e. Aides/Caregivers/Attendants) hereby acknowledge that they **WILL NOT, UNDER ANY CONDITIONS, DISPENSE OR ADMINISTER ANY MEDICATION.**

8. UNDER NO CIRCUMSTANCES are you to ask for, or accept any money from your patient/client or take home property that belongs to the patient client.

9. There shall not be any involvement with the patient/client's financial affairs (i.e. check writing).

10. You are expected to honor the confidentiality of any patient/ client information which is obtained in the regular course of your employment.

11. No personal telephone calls should be made or received by you while on assignment.

12. Please do not discuss your pay or any other personal affairs with the patient/client/family.

13. As an employee of this Agency, you are not authorized to accept any direct employment that may be offered to you by your patient/client/family. If you are requested to do so, please have the patient/client contact us.

14. **It is imperative that all signed notes and documentation including Daily Log, be filled out properly and returned to the office as per our schedule**. If the patient/client is unable to sign your note, a family member or responsible party may sign.

15. During the course of employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.

16. Never leave your patient/client unattended.

Employee Signature_____ Date_____

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CONFIDENTIALITY AND NON-COMPETITION AGREEMENT

Ark Home Health Care requires that the Employee avoid disclosure of confidential information to anyone outside of the Agency and refrain from engaging in unfair competition.

The Employee agrees to refrain from prohibited competition with the Agency and to maintain the confidentiality of information regarding employees, clients and the Agency business.

The Employee will have access to information not generally made available to the public, such as identity of clients, pricing, computer-related programs, etc. The Agency prohibits the utilization of this information for any purposes other than for the Agency's own benefit and prohibits disclosure or unauthorized use during the course of employment or at any time thereafter of any confidential information pertaining to Agency administration and/or projects, or outside investigations of the Agency. The employee is prohibited from disclosing any defaming information regarding Agency personnel and/or personnel incidents related to any violations of the personnel policies.

During the course of employment and for a twelve month period thereafter the Employee is prohibited from engaging in any of the following: induce any employee of the Agency to resign, encourage any client or entity to discontinue any relationship with the Agency, solicit any client of the Agency (current and within the past twelve month period), enter into competitive employment or seek to provide competitive services while employed within twenty-five miles of any office of the Agency, or solicit referrals or opportunities from any referral source.

Upon termination of employment or at the request of the Agency, the Employee is required to return all of the Agency's property including keys, client records, forms, manual, etc. to the Agency and will not retain copies. Failure to return any Agency owned property will result in a $25.00-$100 deduction from the last received paycheck. *(Deduction amount based off of net value of non returned Agency item)*

Violation of this agreement will result in termination and any additional remedy available to the Agency including legal action to remedy all damages including loss of profits, cost of replacing and training employees improperly solicited for competitive employment, etc. .suffered by the Agency. Employee will be required to reimburse the Agency for all legal fees, costs and other expenses.

This agreement is in effect during the Employee's employment and for twelve months thereafter. It does not modify the right of the Employee to resign at any time or of the Agency to terminate employment without prior cause, notice or liability and does not modify any other Agency policy.

_____ _____

Employee Date

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EMPLOYEE POLICIES AND PROCEDURES

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, understand and conform to all applicable Agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Agency's Policy and Procedure on Abuse, Neglect and Exploitation and agree to Comply with and be bound by the Policy.
I understand that information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees, nor is it an expression of my term of employment.

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force on any vehicle I use for the conduction of Agency business during the term of my employment. The Agency has the right to request proof of insurance at any time during the term of employment and that I am required to follow all Agency requirements and state and local laws.

I understand that only the Agency has the authority to admit clients and will supervise with appropriate personnel all services provided.

As a caregiver, I will carry out the plan of treatment, submit time sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans of care, periodic client evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend required staff meeting and in-service training. Home health aides are required to have 12 hours of in-service training annually. I will abide by clock - in/ clock - out calling system.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided. I understand that all information, both written and verbal, regarding client and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease; testing, results or known infection by HIV, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alcohol abuse is protected under specific law. All information in connection with the examination, care or provision of services to any client will not be disclosed without the individual's written consent except as may be necessary to provide services as required by law. Information may be used in statistical or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of client/ employee confidentiality is subject to civil and criminal penalties.
If I mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize the Agency to deduct any amount from my paycheck(s) to correct my accrued or earned sick or vacation leave balance. I understand that this company does not routinely perform drug testing on its employees but may do so at its discretion. I understand that this company is an "At Will" organization and may hire and fire at will.

Employee Signature_____ Date_____

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CRIMINAL HISTORY CHECK, EMPLOYEE MISCONDUCT REGISTRY
NURSE AIDE REGISTRY NOTIFICATION AND STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by the Agency that a criminal history check will be performed on my name. I have informed that Agency of all names (for example, maiden name, aliases) that I have used in the past. I understand that I have been employed on an emergency basis and that my employment is temporary pending the results of the criminal history check. I also understand that if I have been convicted of the following offenses, that I may not be employed by this Agency. I also understand that the Agency will search the Employee Misconduct Registry and the Nurse Aide Registry (if applicable) to determine whether any acts of abuse, neglect or exploitation have occurred and whether my name is designated on either registry. If my name is designated on either registry I understand the Agency must deny me employment.

Offenses which constitute a bar to employment and for which an administrative review is not available, is attached to this document. Please read and inform interviewer if you have one listed.

I understand that all information obtained by this Agency regarding any criminal history will remain confidential. By signing this form, I certify that the information on this form contains no willful misrepresentation and that the information is true and complete to the best of my knowledge.

Applicant Signature _____ Printed Name _____ Date _____

Sec. 250.006. CONVICTIONS BARRING EMPLOYMENT

A person for whom the facility or the individual employer is entitled to obtain criminal history record information may not be employed in a facility or by an individual employer if the person has been convicted of an offense listed in this subsection:

(1) an offense under Chapter 19, Penal Code **(criminal homicide)**;

(2) an offense under Chapter 20, Penal Code **(kidnapping, unlawful restraint, and smuggling of persons);**

(3) an offense under Section 21.02, Penal Code **(continuous sexual abuse of young child or children)**, or Section 21.11, Penal Code **(indecency with a child);**

(4) an offense under Section 22.011, Penal Code **(sexual assault);**

(5) an offense under Section 22.02, Penal Code **(aggravated assault);**

(6) an offense under Section 22.04, Penal Code **(injury to a child, elderly individual, or disabled individual);**

(7) an offense under Section 22.041, Penal Code **(abandoning or endangering child);**

(8) an offense under Section 22.08, Penal Code **(aiding suicide);**

(9) an offense under Section 25.031, Penal Code **(agreement to abduct from custody);**

(10) an offense under Section 25.08, Penal Code **(sale or purchase of child);**

(11) an offense under Section 28.02, Penal Code **(arson);**

(12) an offense under Section 29.02, Penal Code **(robbery);**

(13) an offense under Section 29.03, Penal Code **(aggravated robbery);**

(14) an offense under Section 21.08, Penal Code **(indecent exposure);**

(15) an offense under Section 21.12, Penal Code **(improper relationship between educator and student);**

(16) an offense under Section 21.15, Penal Code **(improper photography or visual recording);**

(17) an offense under Section 22.05, Penal Code **(deadly conduct);**

(18) an offense under Section 22.021, Penal Code **(aggravated sexual assault);**

(19) an offense under Section 22.07, Penal Code **(terroristic threat);**

(20) an offense under Section 32.53, Penal Code **(exploitation of child, elderly individual, or disabled individual);**

(21) an offense under Section 33.021, Penal Code **(online solicitation of a minor);**

(22) an offense under Section 34.02, Penal Code **(money laundering);**

(23) an offense under Section 35A.02, Penal Code **(Medicaid fraud);**

(24) an offense under Section 36.06, Penal Code **(obstruction or retaliation);**

(25) an offense under Section 42.09, Penal Code **(cruelty to livestock animals),** or under Section 42.092, Penal Code **(cruelty to nonlivestock animals);** or

(26) a conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection.

(b) A person may not be employed in a position the duties of which involve direct contact with a consumer in a facility or may not be employed by an individual employer before the fifth anniversary of the date the person is convicted of:

(1) an offense under Section 22.01, Penal Code **(assault)**, that is punishable as a Class A misdemeanor or as a felony;

(2) an offense under Section 30.02, Penal Code **(burglary);**

(3) an offense under Chapter 31, Penal Code **(theft),** that is punishable as a felony;

(4) an offense under Section 32.45, Penal Code **(misapplication of fiduciary property or property of financial institution)**, that is punishable as a Class A misdemeanor or a felony;

(5) an offense under Section 32.46, Penal Code **(securing execution of document by deception)**, that is punishable as a Class A misdemeanor or a felony;

(6) an offense under Section 37.12, Penal Code **(false identification as peace officer; misrepresentation of property);** or

(7) an offense under Section 42.01(a)(7), (8), or (9), Penal Code **(disorderly conduct).**

(c) In addition to the prohibitions on employment prescribed by Subsections (a) and (b), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:

(1) of an offense under Section 30.02, Penal Code **(burglary)**; or

(2) under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.

Text of subsection effective until January 01, 2017

(d) For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Section 5(c), Article

42.12, Code of Criminal Procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

Text of subsection effective on January 01, 2017

(d) For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Article 42A.111, Code of Criminal Procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

Added by Acts 1993, 73rd Leg., ch. 747, Sec. 25, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 14.39, eff. Sept. 1, 1995. Renumbered from Health & Safety Code Sec. 250.005 and amended by Acts 1995, 74th Leg., ch. 831, Sec. 1, eff. June 16, 1995. Amended by Acts 1997, 75th Leg., ch. 482, Sec. 1, eff. Sept. 1, 1997; Acts 1997, 75th Leg., ch. 1159, Sec. 1.33, eff. Sept. 1, 1997; Acts 2001, 77th Leg., ch. 1025, Sec. 6, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 1267, Sec. 5, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 911, Sec. 2, eff. June 20, 2003; Acts 2003, 78th Leg., ch. 1084, Sec. 1, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1209, Sec. 1, eff. Sept. 1, 2003.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 593 (H.B. 8), Sec. 3.44, eff. September 1, 2007.
Acts 2007, 80th Leg., R.S., Ch. 971 (S.B. 199), Sec. 1, eff. September 1, 2007.
Acts 2011, 82nd Leg., R.S., Ch. 817 (H.B. 2609), Sec. 1, eff. September 1, 2011.
Acts 2011, 82nd Leg., R.S., Ch. 879 (S.B. 223), Sec. 3.06, eff. September 1, 2011.
Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 24, eff. September 1, 2011.
Acts 2013, 83rd Leg., R.S., Ch. 363 (H.B. 2683), Sec. 3, eff. January 1, 2014.
Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0757, eff. April 2, 2015.
Acts 2015, 84th Leg., R.S., Ch. 770 (H.B. 2299), Sec. 2.68, eff. January 1, 2017.

Sec. 250.007. RECORDS PRIVILEGED. (a) The criminal history records are for the exclusive use of the regulatory agency, the requesting facility, the private agency on behalf of the requesting facility, the financial management services agency on behalf of the individual employer, the individual employer, and the applicant or employee who is the subject of the records.

(b) All criminal records and reports and the information they contain that are received by the regulatory agency or private agency for the purpose of being forwarded to the requesting facility or received by the financial management services agency under this chapter are privileged information.

(c) The criminal records and reports and the information they contain may not be released or otherwise disclosed to any person or agency except on court order or with the written consent of the person being investigated.

Added by Acts 1993, 73rd Leg., ch. 747, Sec. 25, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 831, Sec. 1, eff. June 16, 1995.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 879 (S.B. 223), Sec. 3.07, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 25, eff. September 1, 2011.

Sec. 250.008. CRIMINAL PENALTY. (a) A person commits an offense if the person releases or otherwise discloses any information received under this chapter except as prescribed by Section 250.007(b) or (c).

(b) An offense under this section is a Class A misdemeanor.

Added by Acts 1993, 73rd Leg., ch. 747, Sec. 25, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 831, Sec. 1, eff. June 16, 1995.

Sec. 250.009. CIVIL LIABILITY. (a) A facility, an officer or employee of a facility, a financial management services agency, or an individual employer is not civilly liable for failure to comply with this chapter if the facility, financial management services agency, or individual employer makes a good faith effort to comply.

(b) A regulatory agency is not civilly liable to a person for criminal history record information forwarded to a requesting facility in accordance with this chapter.

Added by Acts 1993, 73rd Leg., ch. 747, Sec. 25, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 831, Sec. 1, eff. June 16, 1995.
Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 879 (S.B. 223), Sec. 3.08, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 26, eff. September 1, 2011.

Ark Home Health Care
Pediatric/Adult Services
An act of random kindness

PERSONAL PROTECTIVE EQUIPMENT FOR SAFETY AND INFECTION CONTROL ACKNOWLEDGMENT

I understand a Personal Protective Equipment (PPE Kit) is available in the office and contains the following:

- ☐ Barrier Safety Goggles
- ☐ CPR Shield Face Barrier
- ☐ Fluid Resistant Gown
- ☐ Gloves
- ☐ Biohazard Bag
- ☐ Sharps Container
- ☐ 3M Respirator Mask (N95 or similar purchased from Uline.com)

I have been instructed in the use of this equipment and understand that I must comply with Policies and Procedures regarding use of personal protective equipment.

Signature/Title_____ Date_____

Ark Home Health Care
Pediatric/Adult Services
An act of random kindness

INTERVIEW REVIEW

Applicant Name: _____ Date: _____

Days and Hours Available:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Review:

Personality:	☐ Friendly	☐ Average	☐ Quiet
Verbal Skills:	☐ Excellent	☐ Average	☐ Poor
Communication:	☐ Clear	☐ Somewhat Clear	☐ Not Very Clear
Flexibility:	☐ Very Flexible	☐ Somewhat	☐ Not Flexible
Skill level:	☐ Higher Skilled	☐ Moderately Skilled	☐ Lower Skilled
Appearance:	☐ Professional	☐ Semi-Professional	☐ Not Professional

Good Candidate for employment: ☐ YES ☐ NO

OVERALL INTERVIEW:

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_____ _____

Interviewer ***Date***