EMPLOYMENT APPLICATION:

HOMECARE NETWORK OF MICHIGAN INC.

HOMECARE NETWORK OF MICHIGAN TRANSPORTATION, INC.

HOMECARE NETWORK OF MICHIGAN PRIVATE DUTY & SUPPORTED LIVING SERVICES, INC.

HOMECARE NETWORK OF MICHIGAN INC.
HOMECARE NETWORK OF MICHIGAN TRANSPORTATION, INC.
HOMECARE NETWORK OF MICHIGAN PRIVATE DUTY & SUPPORTED LIVING SERVICES, INC.

30777 Northwestern Highway Ste. 105
Farmington Hills, MI 48334
Telephone: (248) 254-3711 Fax: (248) 251-0249
www.hcnmi.com jobs@hcnmi.com

Important Notice:

-Federal law prohibits discrimination based on age, race, religion, sex or national origin. Information given through your profile cannot and will not be used for any discriminatory purpose.
-Complete Background including Drug Screening and Fingerprinting will be **REQUIRED**.
-**If Hired**: You must **Immediately** provide the following: Personal Cell Phone Number & Carrier, Copy of Driver License, Copy of Valid US Citizenship, Copy of SSN Card, Copy of Resume, Copy of YOUR Vehicle Insurance, Copy of YOUR Car Registration, Copy of CPR Card/ First Aide/ ACLS, NEW TB Test Record, Copy of Professional License, Copy of Diplomas/Degrees/ Certification(s), Emergency Contact, Valid Professional References, Form W-4, Form I-9, and Voided Check.

**Falsifying any information will result in an immediate termination and you will be required to pay back any and all fees associated with background check, drug screening, legal fees, contract fees, educational & training fees, legal fees and any and all fees associated with the hiring and employment process.

WHICH POSITION ARE YOU APPLYING FOR?

COMPANY YOU ARE APPLYING WITH:

☐ **Homecare Network of Michigan, Inc.** (DON/DCS, RN, LPN, PT, OT, SLP/ST, MSW, Dietitian, MD/PhD, D.O., Community Liaison)

☐ **Homecare Network of Michigan Private Duty & Supported Living Services, Inc.** (CNA, CENA, Home Health Aide)

☐ **Homecare Network of Michigan Transportation, Inc.** (NEMT Drivers, EMT, Paramedic) Wheelchair Lift Experience/ CDL Required

How were you referred to us?

Please Print

Legal Last Name	Legal First Name	Middle

Other names by which you are known to personal or employment references you have listed (if different from present):

Address

City	State	Zip Code

Home Phone	Business Phone	Cell Phone

E-mail Address:	DATE OF BIRTH: Social Security #: Permanent Resident Card # Expiration Date:
Previous Address / City State ZIP	Emergency Contact / Phone
NURSING License #: Expiration Date:	**CENA** Certificate #: Expiration Date: CNA Certificate #: Expiration Date:
CPR Certification #: Expiration Date:	**Doctors**-MD #: Expiration Date:
Are you **over the age of 21**? ☐Y ☐N If No, Age? _____	Are you a **US Citizen**? ☐Y ☐N If **No**, do you have the legal right and necessary documents to work in the US? ☐Y ☐N
Have you lived in Michigan (MI) 2 years or more? ☐Y ☐N	Can you perform the job functions that are related to the position you are applying for? ☐Y ☐N

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)

Do you possess a valid driver's license in the State of Michigan ☐Y ☐N	Do you currently have **any** driving restrictions? ☐Y ☐N Have you had your driver license suspended or Revoked in the past 5 Years? ☐Y ☐N **Do you have your own valid vehicle insurance? ☐Y ☐N Do you current have a Chauffer Driver License? ☐Y ☐N
Do you own your own reliable transportation (**Own a car**)? ☐Y ☐N	
Will Travel: Check One: ☐Limited / ☐Extensive ☐Out of State	Are you willing to work the hours other than 8am to 5pm? ☐Y ☐N Are you willing to work more than 8 hours per day? ☐Y ☐N Are you willing to work more than 12 hours per day, if needed? ☐Y ☐N Are you willing to work over-night "twig-light" (overnight) shift? ☐Y ☐N Are you willing to be on-call at night or back up for other? ☐Y ☐N Are you willing to Travel with the patient, if asked? ☐Y ☐N Are you willing to use your own car to transport a patient? ☐Y ☐N Are you willing to work with patients that are of unstable mental capacity? ☐Y ☐N Are you willing to be on-call on the weekends as need or required by company? ☐Y ☐N Are you willing to run errands for patients using your own vehicle when working? ☐Y ☐N
Will Relocate: ☐Y ☐N	
Military: From: To: Branch of Service:	**Required**: Please list your current salary and your desired salary: (Base – excludes bonuses and value of benefits) **PLEASE NOTE THAT ALL SALARY INFORMATION WILL BE VERIFIED. PRIOR EMPLOYMENT PAY STUB WILL BE REQUESTED FOR PROOF** Current: $ _____ ←Must include amounts (example $8.00)→ Desired: $ _____ When can you Start:
Hobbies/ Outside Interests	Bilingual Skills? ☐Y ☐N If Yes,_____ Sign Language ☐Y ☐N
Memberships: Professional/Social	

Days available to work:

Sunday:	**Monday:**	**Tuesday:**	**Wednesday:**	**Thursday:**	**Friday:**	**Saturday:**
From: am/pm	**From:** am/pm	**From:** am/pm	**From:** am/pm	**From:** am/pm	**From:** am/pm	**From:** am/pm
To: am/pm	**To:** am/pm	**To:** am/pm	**To:** am/pm	**To:** am/pm	**To:** am/pm	**To:** am/pm

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)

Education Information Name of School(s)	**State**	**Dates Attended** **From / To**	**GPA**	**Graduated?**	**Degree / Title**
H.S.		/		☐ Yes ☐ No	
College or University		/		☐ Yes ☐ No	
Technical School		/		☐ Yes ☐ No	

****Employment**

Please list three individuals who have knowledge of your personal abilities and character.

ALL INFORMATION WILL BE VERFIED

Company Name	Company Address	Title/ Position	Dates Worked?	Supervisor's Name	Work Phone	May We Contact? **If No, Please Explain?**	Salary	Duties	Reason for Leaving
			From: To:			☐ Yes ☐ No			
			From: To:			☐ Yes ☐ No			
			From: To:			☐ Yes ☐ No			
			From: To:			☐ Yes ☐ No			

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****Professional References**

Please list three individuals who have knowledge of your personal abilities and character. **(No Relatives)**

VALID INFORMATION MUST BE PROVIDED, ALL INFORMATION WILL BE VERFIED

Name	Title	Known how long?	Home Phone	Work Phone

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)

Authorization & Notices of Agreement:

I, _____ _____ the undersigned candidate
(Your Name) (Social Security Number)

for employment (with one of the following company(s) Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc.) certify that the facts contained in this application are true and complete and to the best of my knowledge and I understand that, if employed, falsified statements on this application shall be grounds for dismissal. It is my responsibility to ensure that all of the requested documentation listed above under "Important Notice" is submitted within allowable time. It is my responsibility to ensure any and all documentation is submitted, including void check, Form W-4, Form I-9, Garnishment(s), and any and all deductions. I agree that I am responsible to ensure that any specialized taxes and special city taxes are paid by me regardless of the city I reside. I understand and accept that the company(s) has additional fees for processing payroll checks and pay cards of $10 per paycheck or pay cord deposit; there will be a forty dollars ($40) charge for lost paychecks or pay cards; direct deposit is free. I authorize investigation of all statements, records, and position requirements contained herein and the references listed above to give you any and all information they may have, personal or otherwise, and release all parties from all liability for damage that may result from furnishing same to you. I understand that neither this Application nor any communication by a management representative is intended to create or does create a contract of employment, offer promises or employment. I acknowledge that if hired by the company(s), employment is on an at-will basis. This means the company(s) is free to terminate my employment at any time, with or without cause or advance notice, In accordance with state law and acceptance of employment is not a contract of employment for any specified time, similarly, I am free to terminate my employment with the company(s) at any time and for any reason with giving a **REQUIRED minimum two week notice**, which will require that I pick up my last paycheck and sign off on the release of my termination or resignation. It is **unethical** to resign half way through a patient's treatment if you are a professional without a proper two week notice and or in allowing an immediate replacement and proper transitional documentation to another staff as required by the governing bodies. All Staff members are responsible in turning in ALL proper patient documentation within allowable time of 48 hours, including all mileage reimbursement and miscellaneous reimbursement. Failure to perform such a task may be a violation of employment and professional conduct and teaching will be held and or leading up to termination and notification of the staff member's Disciplinary- ***National Council of State Boards &*** Disciplinary- ***Michigan Council of State Boards***, and the company(s) attorney's to take on immediate action, which will include pressing any and all charges necessary. I agree and will be responsible for my actions including ensure that all fees associated with my any of my misconduct are paid by me and hold the company(s) free of any harm or debt. Failure to comply with the company(s) policy will lead to an immediate legal action which will that the staff member will pay for any and all fees associated with such actions. This at-will provision and may be modified or waived only in a written agreement signed by an authorized representative of the company(s) and me. I agree to conform to the rules and regulations of the company(s), I agree to accept the terms of a two year non-solicit (even if terminated o resigned) to any and all company(s) employees, clients, vendors, and all parties affiliated with the company(s) and its operations, and I understand that the company(s) has complete discretion to modify such rules and regulations at any time, except that it will not modify its policy of employment at-will. If Employed by the Company(s), I understand and agree that the Company(s), to extent permitted by federal, state, and local law, may exercise its right, without prior warning or notice, to conduct investigations of property including, but not limited to, files, lockers, desks, vehicles, and computers) and, in certain circumstances, my personal property without hesitation or conditions. **I understand and accept that as a condition of my employment if I quit, resign, and or do not show up at my assigned tasks, and do not notify the company(s) immediately with less than 48 hours, I am to be considered to be resigned/quit and will be responsible to return any and all equipment(s), supplies, patient documentation within allowable time of 48 hours, including all mileage reimbursement and miscellaneous reimbursement, pay (immediate deduction from paycheck will be taken) the company(s) for all background checks, drug screening, fingerprinting, legal fees, child support fees, employment wage garnishment and any garnishment, personal collection agency fees, unauthorized conflict of interest court fees, and any and all fees associated with the company(s), a minimum of two hundred dollars ($200)**. This fee is required regardless of reason for termination/quitting within the first two (2) years. Furthermore, I grant the company(s) above to garnish any assets any wages, personal assets, and personal property in order to pay off any outstanding debts associated or related to me that inflict harm or damage against the company(s). It is my responsibility as an employee or potential employee to inform the company(s) prior to my background check and hiring.

As a condition of my application submission, my potential employment, and or employment I agree to all terms of my employment.

PRINT NAME:

X _____ _____.
First Name Middle Last Name Date

SIGN NAME:

X _____ _____
First Name Middle Last Name Date

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)

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Company(s) Confidentially Statement & Agreements
Company(s) Electronic Privacy Regarding Computer Systems & Usage

Corporate Responsibility

I understand that Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. has established a Corporate Compliance Program to ensure ethical business practices and compliance with applicable laws and regulations. As an employee of the following agency(s) Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc., I agree to comply with the organizations policies and procedures.

Confidentiality of Patient/Co-worker Information

It is Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. policy (and in most cases a legal requirement) that all co-workers protect information regarding patients and other staff. No medical information, including the fact that a person has been treated by Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc., may be released except by authorized persons on a business need to know basis. Any information available to staff about patients, including staff members and their families who are patients, must be kept confidential and not discussed with others, including other staff, except as needed for medical treatment or to comply with legal processes or legal requirements.

Confidentiality of Company Information

I understand Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. confidentiality policy applies to information pertaining to Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. operations, activities and business affairs, including but not limited to charges, reimbursement rates and contracts. All Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. information is to be maintained in strictest confidence and is not to be discussed with anyone other than appropriate personnel, and may not be shared with others outside the workplace, during my employment or post-employment. Any questions with respect to specific instances of release or discussion of confidential information should be directed to your immediate supervisor(s).

System Security

I understand that with access to the Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. computer system, I am responsible to use the system only for work related functions for which I am directly responsible or requested to do by my superior(s). I may not share my system password with another person; leave the password in an unsecured place, nor sign on to the system for an unauthorized person's use. I may only use the single valid system I.D. that has been assigned to me.

Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. maintains an electronic mail and voice-mail system and a corporate network of computer systems and software ("Systems") to assist in the conduct of business within the Company and with Company customers. No personal business should be done with Company electronic property. All Systems are Company property, and such Systems are licensed to Company. All messages composed, sent, or received on these Systems are and remain Company property and are not the private property of any employee. Company management reserves the right to open and/or listen to the e-mail files and voice-mail messages and data files of any employee on any Company computer and/or telephone, at any time, for any reason.

These Systems may not be used to create any offensive, discriminatory, or harassing messages. Prohibited messages include messages that contain sexually explicit or offensive statements, racial slurs, gender-specific comments, or any other comment that addresses

someone's age, sex, religion, national origin, creed, disability, or any other legally protected characteristic in an offensive, discriminatory, or harassing manner.

Employee is aware and consents that there is no expectation of privacy in Company's e-mail and voice-mail systems. Company has the right to access, review, and disclose, at any time, any messages or data created, received, or sent over the Company's Systems for any purpose. The contents of messages and data properly obtained for legitimate business purposes may be disclosed within the Company without the permission of the employee.

Prohibited use of Company Systems includes, but is not limited to, engaging in the following:
a. computer hacking or hacking in general
b. game playing, including online gambling
c. "chat rooms" or chat environments Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. No Expectation of Privacy Policy
d. downloading or uploading games
e. downloading any software or other programs that may cause your computer to be nonfunctional in a network environment
f. disabling or compromising of the security of information contained on Company computers
g. visiting pornographic or sexually explicit, violent, or other unacceptable sites
h. posting company confidential, sensitive, or otherwise proprietary information on the Internet
i. Using social media websites such as Myspace, Facebook, Twitter, or similar sites

I have read and agree to the terms and conditions of this Agreement and I have No Expectation of Privacy Regarding my use of Company's e-Mail, Voice Mail, or Computer Network.

_____ _____

Authorized Representative/ President Date

X_____ _____

Employee Signature Date

System & Equipment Usage

I understand that with access to the Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. computer system, I am responsible to use the system only for work related functions for which I am directly responsible or requested to do by my superior(s). I may not share my system password with another person; leave the password in an unsecured place, nor sign on to the system for an unauthorized person's use. I may only use the single valid system I.D. that has been assigned to me.

I understand that it is my responsibility to ensure that the assigned phone(s), equipment, computers, and any other items are returned in working condition and will ensure the full responsibility of compensating any such repairs to ensure that the system are operational and in working conditions. I hereby understand and authorize any such deduction of wages and or if not employed by the agency will be sure to compensate any such issues. I grant the company(s) above to cease and desist any assets any wages, personal assets, and personal property in order to pay off any outstanding debts associated or related to me that inflict harm or damage against the company(s).

I hereby agree to all Conditions related to the Company(s) Confidentially Statement & Agreements Company(s) Electronic Privacy Regarding Computer Systems & Usage:

I understand that these terms are a condition of my employment:

_____ _____

Authorized Representative/ President Date

X_____ _____

Employee Signature Date

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)

HOMECARE NETWORK OF MICHIGAN INC.
HOMECARE NETWORK OF MICHIGAN TRANSPORTATION, INC.
HOMECARE NETWORK OF MICHIGAN PRIVATE DUTY & SUPPORTED LIVING SERVICES, INC.

MEDICARE FRAUD
OR
UNETHICAL OR ILLEGAL ACTIONS

Any Fraudulent activities will not be tolerated and will be reported to the governing body(ies) and legal actions will be taken immediately.

I, _____ _____ fully understand
(Your Name) (Social Security Number)

that I **will not** commit any illegal act of fraud, theft, and or Medicare or Medicaid Fraud and will be solely responsible for as such acts.

I am fully aware of the company(ies) policies and procedure and will NOT commit such acts. I understand I will be terminated and reported to the proper federal government entity and or agency(ies).

I am fully responsible for my actions and will ensure that **ANY or ALL Financial Obligation** will be paid back should my actions get the agency or me in repayment or audit problem with the governing bodies. I am fully aware and accept all terms of my employment by allowing the agency(ies) and or the governing bodies garnishment my wages and any other garnishment, personal collection agency fees, unauthorized conflict of interest court fees, and any and all fees associated with harming the company(s) due to my unethical actions.

I understand that these terms are a condition of my employment:

_____ _____
Authorized Representative/ President Date

X_____ _____
Employee Signature Date

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)

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AT-WILL Employment Statement

I, _____ _____ fully understand
(Your Name) (Social Security Number)

that my employment with one of the following: Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. is at will and this means that I may terminate employment, any status cannot be modified or altered unless specifically done so in writing and signed by the president of the Company and the employees. All employees accept those with specific written contracts signed by the President is AT-WILL employee. This will void previous agreement verbal or written.

I understand that these terms are a condition of my employment:

_____ _____
Authorized Representative/ President Date

X_____ _____
Employee Signature Date

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)

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INDIVIDUAL STATEMENT REGARDING CONFLICT OF INTEREST

I, _____ _____, have read and
(Your Name) (Social Security Number)

am fully familiar with the agency's policy statement regarding conflict of interest. I am not presently involved in any transaction, investment, or other matter in which I would profit of gain directly or indirectly as a result of my membership on the agency's board of directors or its committees of my employment with one of the following: Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. Furthermore, I agree to disclose any such interest which may occur in accordance with requirements of the policy and agree to abstain which may occur in accordance with the requirements of the policy and agree to abstain from any vote or action regarding the agency's business that might result in any profit or gain, directly or indirectly for myself. I furthermore understand that any allegation brought against any company for conflict of interest will result in me paying for any legal fees, judgment fees, and any other fees associated with this matter. I grant the company(s) above to cease and desist any assets, wages in order to pay off any debts. It is my responsibility as an employee or potential employee to inform the company(s) prior to my background check and hiring.

I understand that these terms are a condition of my employment:

_____ _____
Authorized Representative/ President Date

X_____ _____
Employee Signature Date

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)

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Confidentiality

Purpose:

To state rules and regulations regarding the disclosure of clients' information for all corporation(s)/company(s) of the following:
HOMECARE NETWORK OF MICHIGAN INC.
HOMECARE NETWORK OF MICHIGAN TRANSPORTATION, INC.
HOMECARE NETWORK OF MICHIGAN PRIVATE DUTY & SUPPORTED LIVING SERVICES, INC.

Policy:

Clinical records and client information are held in strict confidence by care personnel.

Procedure:

The Confidentiality policy will be reviewed by the corporation(s)/company(s) president or authorized personnel during the orientation process. A confidentiality statement will be signed and returned to the President prior to patient assignment.
The signed confidentiality statement will be a part of the personnel file.
Access to client information will be limited to those involved in the care/service or supervision of clients.
Clients will not be discussed by clinical or non-clinical personnel outside of the clinical setting. Written consent will be required for release of any client record. The release is signed by the client and/or his/her representative.

Covenant Not-To-Solicit

The employee hereby agrees regardless of the reason of termination of employment with corporation(s)/company(s) that employee shall not, during his/her employment with the corporation(s)/company(s), and for a period of three (3) years from the date of termination of employment, directly or indirectly for his/her benefit, or on behalf of any other, as in individual or as an employee, agent, representative, owner, officer, director, shareholder, partner consultant or franchise of any person, partnership, firm, corporation(s)/company(s) or other entity or otherwise:

- I promise that during my employment I will:
    - Act in the Agency's best interest in all aspects of my duties, in dealing with clients/patients, suppliers, contractors, competitors or any person doing or seeking to do business with the Agency.
    - Avoid any situation, which involves or may involve a conflict between my interests and the interests of the Agency.
    - Refrain from taking part in transactions or activities where I do not believe, in good faith, that I can act on behalf of the best interests of the Agency.
    - Make prompt and full disclosure in writing to the President/Chief Executive Officer any current or potential situation which may involve a conflict of interest.
- situation which may involve a conflict of interest
- Solicit , divert, cause to divert, do business with or take away any business or attempt to solicit, divert any patient which was patient of the corporation(s)/company(s) within a two (2) year period prior to the employee's termination of employment with the corporation(s)/company(s). The employee agrees to be responsible for any and all lost income related to this matter and will be responsible to any and all legal fees and cease and desist of any assets or personal property to ensure that proper compensation is properly paid for lost business.
- Induce or attempt to induce any employee to leave corporation(s)/company(s) employ; solicit, entice, take, divert, or employ any person employed by the corporation(s)/company(s) or otherwise interfere with or disrupt corporation(s)/company(s) relationship with its employees.
- Corporation(s)/Company(s) and employee agree that in the event of breach, or attempted breach, by employee of the covenants set forth herein, corporation(s)/company(s) shall be entitled to institute and prosecute proceedings in any court of competent jurisdiction. Employee acknowledges and agrees that a remedy at law any breach of this agreement, or attempted breach, maybe inadequate and that company will be irreparably harmed. Therefore, employee agrees that in addition to any other remedies available to corporation(s)/company(s), that corporation(s)/company(s) shall be entitle to injunctive and other equitable relief in the event of any such breach or attempted breach. Employee further agrees to waive any requirement for the securing or posting of any bond or other security in connection with obtaining of any such injunction or equitable relief.

I understand that these terms are a condition of my employment:

_____ _____
Authorized Representative/ President Date

X_____ _____
Employee Signature Date

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)

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Company Privacy

I, _____ _____ the undersigned,
(Your Name) (Social Security Number)

understand the importance of observing strict confidentiality policies. Therefore, I agree not to discuss/release any information obtained within the agency regarding all and any of the following agency(s): Homecare Network Of Michigan, Inc. Clients, Their medical record, or any client condition with any individual not directly associated with Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. employee who are not directly associated with that client. I also agree that any information that is released regarding the client or the client's record will only be done with proper authorization and/or in accordance with established agency policy for the release of this information.

My signature on this document indicated that I understand and agree to abide by the aforementioned policies and that any breach in the aforementioned policies will result in implementation of the disciplinary procedure up to and including possible **IMMEDIATE DISMISSAL** from employment at Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc.

I understand that these terms are a condition of my employment:

_____ _____
Authorized Representative/ President Date

X_____ _____
Employee Signature Date

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)

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Missed Visits, Patient Communication Notice, & Signature Logs

This apply(ies) to field staff members

I, _____ _____ have been notified to
(Your Name) (Social Security Number)
report that anytime a patient is admitted to the hospital and or was not seen by me for any reason is my responsibility to notify the agency at 248-254-3711 immediately.

It is also my responsibility to call and verify each week with my client their scheduled visits and ensure that they are available at the times that best that fits.

The Agency will only issue payroll checks according to the patient signature logs and prior approved hours and or visits.

The Agency will not pay you if you go over the approved hours or visits that you have been authorized.

Failure to comply with the Agency may result in my employment termination and understand that my termination was due to lack of my employment compliance with company policy and procedure.

I understand that these terms are a condition of my employment:

_____ _____
Authorized Representative/ President Date

X_____ _____
Employee Signature Date

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HOMECARE NETWORK OF MICHIGAN PRIVATE DUTY & SUPPORTED LIVING SERVICES, INC.

Company Property(ies) Return Agreement (company supplies & equipment)

I, _____ _____ have been
(Your Name) (Social Security Number)
advised by: Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. that any company property(ies) such as supplies and equipment that has been taken out for use must be returned upon request, must be return upon my resignation, must be returned upon my termination, and must be returned upon completion of my assigned tasks.

Failure to returned any company property(ies) such as supplies and equipment that has been taken out for use must be returned upon request, must be return upon my resignation, must be returned upon my termination, and must be returned upon completion of my assigned tasks will result in an immediate legal action on behalf of the agency and I understand that it may be my responsible to pay for any such legal fees in ensuring that all items taken are returned in the proper manner.

I understand that I must pay full value/ equal value for any items that have been given that either that have been lost or damaged.

I understand that these terms are a condition of my employment:

_____ _____
Authorized Representative/ President Date

X_____ _____
Employee Signature Date

HOMECARE NETWORK OF MICHIGAN INC.
HOMECARE NETWORK OF MICHIGAN TRANSPORTATION, INC.
HOMECARE NETWORK OF MICHIGAN PRIVATE DUTY & SUPPORTED LIVING SERVICES, INC.
30777 Northwestern Highway Ste. 105
Farmington Hills, MI 48334
Telephone: (248) 254-3711 Fax: (248) 251-0249
www.hcnmi.com jobs@hcnmi.com

Responsibility and Liability

Relevant Crime Described Under 42 USC 1320a-7(Federal Social Security Act) which includes felony relating to controlled substance, felony relating to health care fraud, criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service, and program related crimes to the delivery of an item or service under subchapter XVIII of Chapter 7 of the Federal Social Security Act or under any state health care program.

I also agree to immediately report whether I become the subject of an order disposition finding of not guilty by reason of insanity under Section 16b of Chapter IX of the Code of Criminal Procedure,1927 PA 175,MCL 769,16b.

I further agree to immediately report being the subject of a substantiated finding of neglect, abuse, or misappropriation of property by a state of federal agency pursuant to an investigation conducted in relation to a skilled nursing facility in accordance with 42 USC 13951-3 or 1396r.

I understand that these terms are a condition of my employment:

_____ _____
Authorized Representative/ President Date

X_____ _____
Employee Signature Date

* Please Note: This notification obligation applies to all workers regardless of their date of hire pursuant to Section 333.20173a of the Public Health Code (P.A. 368 of 1978) and Section 330.1134a of the Mental Health Code (P.A. 258 of 1974). *All Applicants must complete background check forms effective April 1, 2006 this form must be on file for all direct access workers*. Previously signed forms executed pursuant to PA 59 of 2004 and PA 303 of 2002 will be outdated and insufficient.

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)

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Denial of Existence of Criminal History as Required by Public Act XX of 2006*

I, _____ _____ have been
(Your Name) (Social Security Number)
advised by: Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. Clients, Their medical record, or any client condition with any individual not directly associated with Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. Clients, Their medical record, or any client condition with any individual not directly associated with any and all of the following agency(s): Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. that it is necessary to conditionally employ, independently contract and /or grant clinical privileges to me prior to receiving all of the results of the state and national criminal history background information required by Section 333.20173a of the Public Health Code (P.A. 368 of 1978) and Section 330.1134a of the Mental Health Code (P.A. 258 of 1974).Accordingly, I make the following representations while this information is obtained and analyzed:

1. I swear under penalty of law that I have not been convicted of a felony or misdemeanor within the applicable time period that makes me ineligible, by law to work for this organization. I have reviewed the attached list of felonies and misdemeanors prior to making this representation.
2. I am not the subject of an order or disposition under section 16b of chapter IX of the code of criminal procedure, 1927 PA 175, MCL 769, 16(b) relating to findings of not guilty by reason of insanity.
3. I have not been the subject of a substantiated finding of neglect, abuse, or misappropriation of property by state of federal agency pursuant to an investigation arising in a skilled nursing facility and conducted in accordance with 42 USC 13951-3 or 1396r.
4. I agree that, if information in the criminal history investigation conducted by : Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. Clients, Their medical record, or any client condition with any individual not directly associated with Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. does not confirms my statements, my employment, contract or clinical privileges will be terminated unless and until I can prove that the information is incorrect I further agree that if this results in a period of unemployment, suspension, or leave of absence, it will be without compensation and without fringe benefits
5. I understand that conditions set forth in Section 333.20173a of the Public Health Code (P.A. 368 of 1978) and Section 330.1134a of the Mental Health Code (P.A. 258 of 1974) that results in my termination and agree that these conditions are in fact good cause of termination.
6. I am aware that the provision of false information regarding my identity or criminal history is a crime punishable by fines and/or imprisonment.

7. **Miscellaneous:**

- The agreement may only be amended by a written document signed by one of the following agency(s) President: Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. Clients, Their medical record, or any client condition with any individual not directly associated with Homecare Network Of

Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. and the employee.

- No Provision in this agreement shall be affected by the invalidity of any other provision.
- This agreement shall be interpreted in accordance with the laws of Michigan.
- Employee is responsible for any company items used or damaged during this time. Employee will be responsible to back money(ies) for any damages.
- The employee will not take or visit any Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. Clients, Their medical record, or any client condition with any individual not directly associated with Homecare Network Of Michigan, Inc.; Homecare Network of Michigan Transportation, Inc.; and Homecare Network of Michigan Private Duty & Supported Living Services, Inc. patient in case of termination or voluntary leave of the employee.

I understand that these terms are a condition of my employment:

_____ _____

Authorized Representative/ President Date

X_____ _____

Employee Signature Date

otification and Authorization to Conduct Employment Background Investigation

THIS FORM IS REQUIRED TO BE COMPLETED PRIOR TO AND BEFORE FOR EMPLOYMENT
ONCE SUBMITTED IT MAY TAKE UP TO 14 BUSINESS DAYS TO HAVE THE REPORT COMPLETED

I hereby authorize **JUSTIFACTS CREDENTIAL VERIFICATION, INC.**, an Agent for **HOMECARE NETWORK OF MICHIGAN, INC.; HOMECARE NETWORK OF MICHIGAN TRANSPORTATION INC.; HOMECARE NETWORK OF MICHIGAN PRIVATE DUTY & SUPPORTED LIVING SERVICES INC.** to ascertain information regarding my background to determine any and all information of concern to my record, whether same is of record or not, and I release employers and persons named in my application from all liability for any damages on account of his/her furnishing said information. I understand that this form indicates that a background search will be conducted and that this is my notification of that intent, I authorize **JUSTIFACTS CREDENTIAL VERIFICATION, INC.** to perform this complete check as requested by the Agent(s) Company(s) **as many as six (6) times per given year and for as long as I am employed by the Agent(s) Company(s)**. I understand that the purpose of this background investigation is to determine my suitability for employment and may elicit information on my character, general reputation, personal characteristics and mode of living. Additionally, you are hereby authorized to make any investigation of my personal history, educational background, military record, motor vehicle records, criminal records, and credit history through an investigative or credit agency or bureau of your choice. I authorize the release of this information by the appropriate agencies to the investigating service. This authorization, in original or copy form, shall be valid for this and all subsequent reports needed as it pertains to employment.

PLEASE PRINT CLEARLY

FULL NAME: _____

OTHER NAMES USED/MAIDEN NAME/DATES: _____

CURRENT
ADDRESS: _____ PHONE: _____

LIST ALL ADDRESSES FOR PAST 7 YEARS:

_____ Dates: _____

_____ Dates: _____

_____ Dates: _____

_____ Dates: _____

EMAIL ADDRESS: _____

SOCIAL SECURITY # ___-___-___ DATE OF BIRTH: _____
xxx xx xxxx mm/dd/yyyy

DRIVER'S LICENSE # ___-___-___-___-___EXPIRE Date: _____ STATE ISSUED: _____
x xxx xxx xxx xxx mm/dd/yyyy

***** MAY WE CONTACT YOUR CURRENT EMPLOYER? YES _____ NO _____**

***** HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES _____ NO_____**

If yes, please explain: _____

_____

SIGNATURE:X_____ DATE:_____

Notice to California Applicants

(You may omit minor traffic offenses, any convictions which have been sealed, expunged or statutorily eradicated, convictions more than two years old for the following marijuana related offenses: HS11357b&c, HS11360c, HS11364, HS11365, HS11550, and misdemeanors for which probation was completed and the case was judicially dismissed)
***Note**: No applicant will be denied employment solely on the grounds of conviction of a crime. The nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense to the position will be considered.*

Under Section 1786.22 of the California Civil Code, you have the right to request from Justifacts, upon proper identification, the nature and substance of all information in its files on you, including the sources of information, and the recipients of any reports on you to whom Justifacts has previously furnished within the two-year period preceding your request. You may view the file maintained on you by Justifacts during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services. Upon making a written request, you may receive a summary of your report via telephone.

California, Minnesota & Oklahoma Applicants Only: Please check this box if you would like a copy of the background check mailed to you. Minnesota and Oklahoma applicants will receive a copy direct from Justifacts or its designee. California applicants may receive a copy from either the prospective employer or Justifacts.
NOTICE: Under federal law, you have the right to request disclosure of the nature and scope of our investigation by providing us with a written request within 60 days of our background investigation.

Subscriber certifies that consumer credit information, consumer reports, as defined by the Fair Credit Reporting Act, 15 U.S.C. 1681 at seq. ("FCRA"), will be ordered only when intended to be used as a factor in establishing a consumer's eligibility for employment and that consumer credit information will be used for no other purposes. It is recognized and understood that the FCRA provides that anyone "who knowingly and willfully obtains information on a consumer from a consumer reporting agency" (such as Justifacts) "under false pretenses shall be fined not more than $5,000 or imprisoned not more than two years or both." REV. 3/05

Applicant have read and agrees to all the terms and conditions on this page _____ (initials) _____ (Date)