Visions
for your community
Home Health Care
Alpine Executive Center, P.O. BOX 1171, 400 W. Main St., Suite 204, Gaylord, MI 49734
: (989) 370-3805 : (989)803-5930 info@visionshomehealthcareagency.com
www.visionshomehealthcareagency.com
"Going above and beyond your expectations with dignity and respect."

Name:_____DOH:_____

New Hire Packet Checklist

Applicant requirements:

Completed Documents:

___ Employment Application Form
___ Job Description & Acknowledgement
___ Legal Disclosures and Agreement
___ Criminal Background Check Policy and Disclosure
___ Additional disclosures and Agreement
___ Non-compete Agreement
___ Emergency Contact Information Form
___ False Claims Policy Act
___ Medical conditions Experiences and Knowledge (with client) Questionnaire
___ Previous Employer Reference Contact Form
___ Direct Deposit Form
___ I-9
Tax Documents:
___ W-9
___ W-4 (___Federal ; ___ State)

Provided copies of the following:
___ Valid Driver's License
___ Social Security Number Card
___ Auto Insurance Policy
___ Updated CPR Certification
___ TB test Results
___ CNA, Nursing or other Educational Certifications/Licenses
___Resume (If any)

Office requirements:

___ *Pre-Employment Interview* ___ *Background Check _Ichat _Sam _OIG*
Completed by:_____ Date: _____
___ *Reference Check: ____ Contact or ____ Previous employer*
___ *Orientation:*
___ *Handbook: Policy Manual*
___ *Signed Acknowledgement Receipt of Policy Manual*
___ *HIPAA Privacy Act Video* ___*Person Centered Planning (PCP)*
___ *Training:*
___ *When I Work* ___ *Scheduling with scheduler* ___ *Boundaries*

OFFICE USE ONLY: (Initials/Date)

Supervisor list:_____ Payroll Info forwarded: _____

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Employment Application Form

Today's Date:_____

Position Applied for:_____ Location:_____

How did you hear about this job opportunity? (Please specify ad other source) _____

Visions for your community Home Health Care Agency, LLC (Visions) is an Equal Opportunity Employer (EOE). Visions provides equal employment and advancement opportunities to all qualified staff members and applicants for employment without respect to race, color, religion, national origin, LGBTIQ status, veteran status, sex, age, disability, or any other protected class under the law. Visions does not condone and will not tolerate discrimination, intimidation, or harassment based on this factors, and sexual harassment is prohibited whether directed toward women or men. Such conduct will subject the employee to disciplinary action, up to and including immediate termination. We **do not tolerate** any employee engaging in harassment or discrimination of any kind. Please see our "Non-Discrimination and Anti-Harassment Policy" and our "Sexual Harassment Policy."

Visions will make reasonable accommodations for qualified individuals with known disabilities unless doing so would result in an undue hardship. This policy governs all aspects of employment, including selection, job assignment, compensation, discipline, termination, and access to benefits and training.

Last Name:	First Name:	Middle Name:

Present Address

Street:	City:	State:	Zip code:
		MI	

Phone Number

Home:	Cellular:	E-Mail:

Are you a U.S. Citizen, permanent resident, or a foreign national with authorization to work in the United States?	Yes	No
Are you able to perform the essential functions of the job for which you are applying, either with or without reasonable accommodation?	Yes	No
Have you worked for Visions previously?	Yes	No
Resume attached?	Yes	No

EMPLOYMENT HISTORY-Please include four (4) most recent employers. Do not omit any employers.

Name of Employer:	Employers Address:

Your Job Title:	Employers Phone number:	Supervisor's Name:

From (Month/Year)	To (Month/Year)	Hours per Week	May we contact this employer?
			YES or NO

Reason for leaving?

_____

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Your Job Title:	Employers Phone number:	Supervisor's Name:

From (Month/Year)	To (Month/Year)	Hours per Week	May we contact this employer?
			YES or NO

Reason for leaving?

____

Name of Employer:	Employers Address:

Your Job Title:	Employers Phone number:	Supervisor's Name:

From (Month/Year)	To (Month/Year)	Hours per Week	May we contact this employer?
			YES or NO

Reason for leaving?

____

Name of Employer:	Employers Address:

Your Job Title:	Employers Phone number:	Supervisor's Name:

From (Month/Year)	To (Month/Year)	Hours per Week	May we contact this employer?
			YES or NO

Reason for leaving?

____

Please explain any lapses in prior employment:

The following information is for purpose of considering your requests, and it does not constitute a promise or guarantee of employment:

Times available to work: (be specific as to hours and days)	What days and times are you not able to work?	On what date would you be available to start work?
Are you able to report to work punctually and regularly?	Wage expectations? $________________	How many hours per week are you available to work?

Why do you feel that you are qualified to perform the work for which you are applying?

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Do you have a reliable means of transportation to get to work on time and home safely?

EDUCATION	Name and City	Number of Yrs. Completed	Did You Graduate?	Degrees Received
High School				
College				
Post-College				
Other Education (Trade School)				

Do you have any computer skills? If yes, please describe.
Please list any specific skills that may be relevant to the position for which you are applying.
Have you had any previous experiences or contacts with our Company?
Why would you like to work for the Company?

REFERENCES

Please list only professional references. If you need more space, please use the back of this application.

Name	Company Name	Business Phone Number (No Cell phone Numbers)	Business E-Mail	How do you know this person?	Years Acquainted?

DO NOT SIGN AS REQUESTED BELOW UNTIL YOU HAVE READ THIS ENTIRE DOCUMENT, UNDERSTAND ITS TERMS AND CONDITIONS, AND AGREE TO THE TERMS AND CONDITIONS SET FORTH HEREIN. YOUR SIGNATURE BELOW INDICATES YOUR AGREEMENT TO THE TERMS AND CONDITIONS SET FORTH IN THIS APPLICATION. THE CONSIDERATION FOR YOUR ACCEPTANCE OF THE TERMS AND CONDITIONS SET FORTH HEREIN IS THE COMPANY'S WILLINGNESS TO REVIEW YOUR APPLICATION AND EMPLOYMENT IF YOU ARE SELECTED FOR EMPLOYMENT.

By signing below, I certify that all answers to questions in the application, and other reference documents referenced above are true and complete to the best of my knowledge. I understand that misinterpretation, omission, or falsified statements on this Application or any other reference documents in any detail shall constitute sufficient cause for disqualification from further consideration for hire or for dismissal whenever discovered.

_____ _____

APPLICANT'S SIGNATURE DATE

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ADDITIONAL DISCLOSURES AND AGREEMENTS

I also understand that if I am hired, I will be required to provide proof of identity and legal authorization to work in the United States, and that federal immigration laws require me to complete an I-9 Form in this regard. I further understand that to be eligible for employment, I must complete the entire application process which may include a medical examination.

I expressly authorize, without reservation, Visions for your community Home Health Care Agency, its representatives, employees or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application, resume or job interview. I hereby waive any and all rights and claims I may have regarding the company, it's agents, employees or representatives, for seeking, gathering and using truthful and non-defamatory information, In a lawful manner, in the employment process and all other persons, corporations or organizations for furnishing such information about me.

In order to process your application, or during the course of your employment, a consumer report may be obtained on you employment purposes. It may be an investigative consumer report that includes information regarding your character, general reputation, personal characteristics and mode of living. Such report may also be necessary in relation to any investigation regarding allegations of sexual harassment, discrimination, or disciplinary charges associated with your employment. The employer may utilize an outside organization to obtain a consumer report and/or to conduct investigations. If an investigative consumer report is obtained, you have a right to request disclosure of the nature and scope of the report, which involves personal interviews with sources such as your neighbors, friends or associates. I hereby authorize the employer to obtain a consumer report on me for employment purposes and to conduct investigations as outlined above.

I understand that Visions for your community Home Health Care Agency does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or eliminating any applicant from consideration for employment on any basis prohibited by applicable local, state or federal law.

I understand that this application remains current for only 30 days. At the conclusion of that time, if I have not heard from the company and still wish to be considered for employment, it will be necessary for me to reapply and complete a new application.

In consideration of my employment, I agree to conform to the company's rules and regulations, and I agree that my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, at either my or the company's option. I also understand and agree that the terms and conditions of my employment may be changed, with or without cause, and with or without notice, and anytime by the company. I understand that no company representative, other than its President, and then only when in writing and signed by the President, has any authority to enter into any agreement for employment for any specific period of time, or to make any agreement contrary to the foregoing.

I further agree that, if employed, I will confirm my conduct to Visions' rules and regulations, and that I may not enter into any other employment or engage in any business which will conflict with my responsibilities as an employee of Visions for your community Home Health Care Agency.

By signing below, I certify that all answers to questions in the application, and other reference documents referenced above are true and complete to the best of my knowledge. I understand that misrepresentation, omission, or falsified statements on this application or any other reference documents in any detail shall constitute sufficient cause for disqualification from further consideration for hire or for dismissal whenever discovered.

Applicant's Signature:_____ Date: _____

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CRIMINAL BACKGROUND CHECK POLICY AND DISCLOSURE

As a condition of employment, each employee is subject to a criminal background check. In conducting criminal background checks, VIsions for your community Home Health Care Agency, will comply with federal laws that protect applicants and employees from discrimination. That includes discrimination based on race, color, national origin, sex, GBLT status, religion; disability; genetic information (including family medical history); and age(40 or older).

In addition, Visions for your community Home Health Care Agency, to the extent required, will comply with the Fair Credit Reporting Act (FCRA) with regard to conducting criminal background checks. The Federal Trade Commission (FTC) enforces the FCRA.

Although a disqualification is possible, in accordance with federal and state laws, a previous conviction does not automatically disqualify an applicant from consideration for employment with Visions, unless such employment involves working with children and the conviction or criminal conduct relates to children or is clean record is required given the job duties, funding source, or employment source.

In conducting criminal background checks and convictions, Visions complies with the EEOC guidelines regarding the use of criminal background checks and specifically follows the "Green Factors" set forth in *Green v. Missouri Pacific Railroad*. The "Green Factors" requires Visions to evaluate the criminal background check report under the following test which assesses whether an exclusion is job related for the position in question and consistent with business necessity:

- The nature and gravity of the offense or conduct:
- The time that has passed since the offense or conduct and/or completion of the sentence; and
- The nature of the job held or sought.

To the extent that the criminal background check reveals conduct that would exclude the person from the specific job applied for after applying the "Green Factors", and to the extent that the basis for denying the job was related to the criminal background check, Visions will send out an appropriate letter to the prospective employee explaining the basis for denial of the job. The prospective employee shall have 10 days after the date of the correspondence explaining the basis for denial of the job to contact Visions and schedule a meeting explaining how the criminal background conduct should not exclude him/her. Failure by the prospective employee to contact Visions within the ten (10) day period as provided above, shall constitute of waiver of such right to engage Visions regarding the decision to deny employment.

If you have any questions regarding your rights, please feel free to contact the Human Resource Department of Visions or the EEOC at www.eeoc.gov.

By signing this application, I certify that all the answers to questions in the application, and other reference documents are true and complete to the best of my knowledge. I understand that misrepresentation, omission, or falsified statements on this application or any other reference documents in any detail shall constitute sufficient cause for disqualification from further consideration for hire or for dismissal whenever discovered.

Applicant's Signature:_____ Date: _____

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LEGAL DISCLOSURES AND AGREEMENT

TO THE EXTENT PERMITTED BY STATE LAW, I UNDERSTAND AND AGREE THAT I SHALL NOT COMMENCE ANY FEDERAL (NOT REQUIRING FILING WITH THE EEOC, AND NLRB OR OTHER ADMINISTRATIVE AGENCY FIRST) OR STATE LAW ACTION OR SUIT RELATED TO MY EMPLOYMENT WITH VISIONS: 1) MORE THAN SIX MONTHS AFTER THE TERMINATION OF MY APPOINTMENT, IF THE ACTION OR SUIT IS RELATED TO THE TERMINATION OF MY EMPLOYMENT; OR 2) MORE THAN SIX MONTHS AFTER THE EVENT OR OCCURRENCE ON WHICH MY CLAIM IS BASED, IF THE ACTION OR SUIT IS BASED ON AN EVENT OR OCCURRENCE OTHER THAN THE TERMINATION OF MY EMPLOYMENT. WHILE I UNDERSTAND THAT THE STATUTE OF LIMITATIONS FOR FEDERAL AND/OR STATE LAW CLAIMS ARISING OUT OF MY APPOINTMENT WITH VISIONS MAY BE LONGER THAN SIX MONTHS, I AGREE TO BE BOUND BY THE SIX (6) MONTH PERIOD OF LIMITATIONS SET FORTH HEREIN AND I WAIVE ANY STATUTE OF LIMITATIONS TO THE CONTRARY. SHOULD A COURT DETERMINE IN SOME FUTURE LAWSUIT THAT THIS PROVISION ALLOWS AN UNREASONABLE SHORT PERIOD OF TIME TO COMMENCE A LAWSUIT, THE COURT SHALL ENFORCE THIS PROVISION AS FAR AS POSSIBLE AND SHALL DECLARE THE LAWSUIT BARRED UNLESS IT WAS BROUGHT WITHIN THE MINIMUM REASONABLE TIME WITHIN WHICH THE SUIT SHOULD HAVE BEEN COMMENCED.

TO THE EXTENT PERMITTED BY LAW, I UNDERSTAND AND AGREE THAT ANY FEDERAL LAW CLAIM OR LAWSUIT REQUIRING TO BE SUBMITTED TO THE EEOC, NLRB OR ANY OTHER ADMINISTRATIVE AGENCY BEFORE FILING SUIT RELATING TO MY EMPLOYMENT WITH VISIONS MUST BE FILED NO MORE THAN 185 DAYS AFTER THE DATE OF FILING A PROPER AND TIMELY CHARGE WITH THE EEOC, NLRB, OR ANY OTHER ADMINISTRATIVE AGENCY HAS EXPIRED. WHILE I UNDERSTAND THAT THE STATUTE OF LIMITATIONS FOR CLAIMS ARISING OUT OF AN EMPLOYMENT ACTION MAY BE LONGER THAN 185 DAYS, I WAIVE ANY STATUTE OF LIMITATIONS TO THE CONTRARY.

BY SIGNING THIS DOCUMENT, I CERTIFY THAT I HAVE READ THIS LEGAL DISCLOSURES AND AGREEMENT SET FORTH ABOVE, HAD THREE DAYS TO DISCUSS THE LEGAL DISCLOSURES AND AGREEMENT WITH COUNSEL OF MY CHOICE, AND DECIDED TO MOVE FORWARD AND SIGN BELOW, AND UNDERSTAND THAT WITHOUT MY AGREEMENT TO THE LEGAL DISCLOSURES AND AGREEMENT, VISIONS WOULD NOT CONSIDER MY APPLICATION FOR EMPLOYMENT. I FURTHER UNDERSTAND AND REQUEST THAT THE LIMITATIONS BE STRICTLY ENFORCED AND THAT I AM SIGNING THE LIMITATIONS AS MY OWN FREE WILL.

ADDITIONALLY, I ACKNOWLEDGE THAT I HAVE THREE (3) DAYS AFTER SIGNING THE LEGAL DISCLOSURE IN AGREEMENT TO RESCIND MY SIGNATURE. I UNDERSTAND THAT SUCH ACTION WILL RESULT IN MY EMPLOYMENT BEING TERMINATED BECAUSE SUCH LEGAL DISCLOSURE IS A CONDITION OF MY JOB. BY NOT RESCINDING MY SIGNATURE TO THIS PROVISION WITHIN THE THREE (3) DAYS PERIOD, I AM ACKNOWLEDGING MY CONSENT TO THIS LEGAL DISCLOSURE AND AGREEMENT.

Applicant's Signature:_____ Date: _____

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NON-COMPETE AGREEMENT

The Parties hereby understand that there exists a contractual relationship between Visions for your Community Home Health Care Agency, LLC. Hereafter, "Visions" and you as an employee or sub-contractor. As a result of this relationship, employees and sub-contractor has learned or will learn personal information of its clients (including names, addresses, phone number, names of relatives, financial information and the like). You will also learn of proprietary information belonging to and or developed by visions. The Parties also understand that Visions has devoted considerable resources in the acquisition of clients. The Parties further understand the importance to protect the relationships between Visions and its clients and to protect Visions proprietary information.

Therefore, in order to maintain the viability of Visions and to protect the privacy of Visions clients, the Parties agree as a condition of employee and sub-contractor's employment with Visions, the following:

During the contract period and during a two-year period at the date of termination, whether voluntary or involuntary, thereafter, employee and sub-contractors shall NOT partake in the following within 100-mile radius of Gaylord, Michigan, USA:

1.) Directly or indirectly, render home health care services to any past or current clients of Visions, with the exception of clients funded by medicaid waiver programs.
2.) Directly or indirectly, solicit home health care services on behalf of any third party to any past or current clients of Visions, with the exception of clients funded by medicaid waiver programs.
3.) Be employed as an employee or subcontractor for any third party (person or entity) providing home health care services with the exceptions of clients funded by medicaid waiver programs.
4.) Be self-employed providing home health care services.
5.) Provide any third party (either a person or entity) any personal information, including but not limited to, Phone numbers, addresses, relative's names, financial information of any past or current client of Visions.
6.) Provide any third party (person or entity) any proprietary information of Visions, including, but not limited to its pay structure, the contents of it's contracts it's clients lists, prospective client lists and the like.

If there is a breach of the Agreement, the Employee or the subcontractor shall pay to Visions an amount equal to the greater of:

a) The billings to such client by Visions during the twelve (12) month period immediately preceding the effective date of termination, or
b) The average annual billings to such client by Visions during the three-year period preceding the effective date of termination.

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The payments shall be due to Visions at the time the sub-contractor first renders services to such client(s) of Visions.

For purpose of the Agreement, a "Visions Client" is any person or entity for the Visions providing home health care services of any kind at the time of the sub-contractor's termination of employment or at any time during the 24 months preceding such termination and any successor or assign of any such person or entity, with the exception of clients funded by medicaid waiver programs.

Furthermore, nothing herein shall prohibit Visions from filing suit in the Circuit Court for the County of Otsego or Other Counties to request both equitable or legal relief and/or monetary damages as set forth above. The Employee or Subcontractor further agrees, if Visions files such a suit Employee or Subcontractor shall also be liable to Visions for all of it's actual attorney fees and costs in bringing such an action.

Name of Contractor: _____ Signature: _____

Supervisor Signature: _____ Today's Date: _____

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Emergency Contact Information Form

Name:

Full Address:

Mobile phone: Home phone:

E-mail Address: Date of Birth:

Driver's License: SSN:

Primary Physician's Name & Contact Number:

Hospital of Preference:

Health History:

Previous Medical condition/s

Any known Allergies:

Emergency Contact:

Name: Relationship to you: Mobile Home phone number:

Street Address, City, State, Zip Code:

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Medical conditions Experiences and Knowledge (with client) Questionnaire
(Please check one each line)

Name:_____ **Date:**_____

Conditions	Experienced	Basic	None at all
Alzheimer's Disease			
Senility			
Hearing Impairment			
Anger/Agitation			
Dementia			
Hallucination			
Parkinson's Disease			
Diabetes			
Screaming/Verbal Noise			
Stressful Situations			
Sleeping Problem			
Strokes			
Cancer			
Heart Attack			
Mental Illness			
Congestive Heart Failure			
Renal Failure			
Seizures			
Yeast Infection			
Bladder Infection			
Constipation			
Diarrhea			
Asthma			

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Name:_____ **Date:**_____			
Fracture			
Sprain			
Lou-Gehrig Disease			
Neck Brace			
AIDS			
HIV			
Terminal Illness			
Sponge/Tub Bathing			
Ulcers/Wound Care			
Amputation Care			
CPR certified			
First Aid Procedures			
Burns			
Ambulation/Transfers			
Emptying Catheter/Replace			
Catheterization by hand			
Catheter Cleaning			
Incontinence Care			
Colostomy bag/Changing			
Gate Belts			
Insulin Set Up/Administering			
Heimlich Maneuver			
Hoyer Lift			
Range of Motions			
Slide Board/Transfers			

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Name:_____ **Date:**_____			
Set-up/Dispense Medications			
Specialized Diets			
Blood Glucose Testing			
Taking Blood Sugar			
Taking Pulses			
Taking Respirations			
Temperature Reduction			
Tube Feeding/Manually			
Tube Feeding/Machine			
House Cleaning			
Bedridden Client Care			
Decubitus /Bed Sores			
Preventing skin breakdowns			
Prosthesis			
Dialysis			
Wheel Chairs			
Walkers			
Oxygen Tanks			
Oxygen Care			
Nebulizer/Inhalers			
Sit to Stand Assist Machine			
Hand Feeding People			

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False Claims Policy Act

Policy:
Under the Deficit Reduction Act of 2005, the Region 9 Area Agency on Aging (AAA) and Visions for your Community Home Health Care Agency is required to provide employees, provider and volunteers with information regarding federal and state false claims laws, administrative remedies under those laws, whistleblower protections to employees who report incidents of false claims, and Region 9 AAA's and Visions for your Community Home Health Care Agency methods for detecting and preventing fraud, waste, and abuse in Medicaid programs.

Purpose:
The purpose of this policy is to ensure that employees, providers and volunteers fully understand the requirements of the Deficit Reduction Act of 2005 which contains provisions to combat fraud and abuse in government healthcare programs.

Procedure:
The policy is intended to cover the following Acts:

Federal False Claims Act
The False Claims Act prohibits any person from knowingly presenting or causing to be presented, a false or fraudulent claim to the United States government for payment. The False Claims Act imposes civil liability on any person who:

- Knowingly presents a false or fraudulent claim of payment of approval.
- Knowingly makes or uses a false record or statement to get false or fraudulent claim paid or approved.
- Conspires with another to get a false or fraudulent claim paid or allowed.
- Knowingly makes or uses false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.
- Commits other fraudulent acts enumerated in the statue.

Medicaid False Claim Act *(M.C.L. 400.601 et seq.)*
The State of Michigan has a companion law known as the Medicaid False Claims Act. This act imposes prison terms of up to four (4) years and fines up to $50,000 for:

- Knowingly making a false statement or false representation of material fact in any application for Medicaid benefits or for use in determining right to a Medicaid benefit;
- Concealing or failing to report an event which would affect the person's right to receive or continue to receive benefits;
- Soliciting, offering or receiving kickbacks or bribes for referrals to another for Medicaid funded services (fine up to $30,000);
- Entering an agreement with another to defraud Medicaid through a False Claim; or
- Making or presenting to the State of Michigan a False Claim for payment.

Safeguards:
Both the federal and Michigan False Claims Acts provide for criminal penalties and include a whistleblower provision to report misconduct involving false claims. This provision allows any private person with actual knowledge of allegedly false claims to file a lawsuit on behalf of the United States government or State government as the case may be.

The federal or state government has the opportunity to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the government decides to intervene, the private person who initiated the action may be eligible for a portion of the proceeds of the action or settlement. The person filing such an action may also receive an amount for reasonable expenses, including reasonable attorney fees and costs incurred in connection with bringing the lawsuit.

Violations of the federal false claims act can result in penalties of not less than $5,500.00 and not more than $11,000.00 per claim, plus three (3) times the amount of damages that the government sustains. The Michigan act makes violation a felony punishable by imprisonment and fines up to $50,000.00.

Whistleblower Protection Laws:
In addition to NEMCSA/Region 9 AAA's and Visions for your Community Home Health Care Agency Whistleblowing Policy (See personnel policies), both the federal and state laws protect individuals who investigate or report possible False Claims Act violations made by their employer against discharge or discrimination in employment because of participation in such investigation. Employees who are discriminated against or are subjected to adverse employment actions based on good faith participation in an investigation may sue in court for damages. Under either the federal or state law, any employer who violates the whistleblower protection law is liable to the employer for (1) reinstatement of the employee's position without loss of seniority, (2) two times the amount of lost back pay, (3) interest and compensation for any special damages, and such other relief necessary to make the employee whole.

Detection of Potential Fraud or Abuse:
The Region 9 AAA and Visions for your Community Home Health Care Agency combats Medicaid fraud, waste and abuse by investigating complaints, raising awareness of anti-fraud initiatives, and assuring compliance with the state and federal laws. Quality measures are also used to detect and prevent potential fraud, waste or abuse that includes the following:

- Proactive review of claims and other types of data
- Recommending and implementing claims processing safeguards
- Conducting employee education on fraud and abuse prevention, recognition and reporting
- Encourage and promote the reporting of fraud or abuse by employees and contractors

Types of Fraud Prosecuted Under the MFCA:

- Billing for goods and services that were not delivered or rendered

- Submitting false service records or samples in order to show better-than-actual performance
- Performing inappropriate or unnecessary medical procedure
- Providing inappropriate or unnecessary medical equipment.
- Billing in order to increase revenue instead of billing to reflect actual work performed
- Up-coding, or inflating bills by using diagnosis billing codes that suggests a more expensive illness or treatment
- Double billing or charging more than once for the same service or goods
- Prescribing a medicine or recommending a type of treatment regimen in order to earn kickbacks from hospital, labs or pharmaceutical companies
- Billing for work or test that were not performed
- Phantom employees and doctored time slip: charging for employees that were not actually on the job, or billing for made-up hours in order to maximize reimbursements
- A grant recipient charging grantor for costs not related to the program
- Making or inducing another to make false statements or using false records to obtain or continue Medicaid eligibility.

Notice/Information:
The Region 9 AAA and Visions for your Community Home Health Care Agency prohibits the actions listed above, and any other action (or inaction) that results in fraud, waste, or abuse of public resources, and shall provide all employees, contractors and agents with a copy of this policy to inform them about the federal and state false claim laws. This policy shall be included in the Region 9 AAA's and Visions for your Community Home Health Care Agency Programmatic Policies and referred to in vendor Contract Standards as well as distributed to all contractors and agents as required by the Deficit Reduction Act of 2005.

The following websites outlines the provisions of the Acts:

Federal False Claims Act: http://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_primer.pdf

Michigan's The Whistleblower's Protection Act:
https://www.legislature.mi.gov/documents/mcl/pdf/mcl-Act-469-of-1980.pdf

Michigan's Medicaid False Claim Act
http://www.legislature.mi.gov/(S(uvbpiunp3dyxlovaelkoeyts))/mileg.aspx?page=getobject&objectname=mcl-Act-72-of-1977&query=on&highlight=medicaid

Response/Reporting:
To the extent that Region 9 AAA and Visions for your Community Home Health Care Agency becomes aware of suspects fraud or abuse, it is obligated to respond in accordance with Federal and State regulations.

Visions
for your community
Home Health Care
Alpine Executive Center, P.O. BOX 1171, 400 W. Main St., Suite 204, Gaylord, MI 49734
(989) 370-3805 (989)803-5930 info@visionshomehealthcareagency.com
www.visionshomehealthcareagency.com
"Going above and beyond your expectations with dignity and respect."

To report Medicaid Fraud:
http://www.michigan.gove/mdch/0,1607,7-132-2945_42542_42543_4246_42551-220188--,00.html

Enforcement:
All management level personnel are responsible for enforcing this policy. All **employees, vendors and volunteers** will be given a copy of this policy and requested to sign an attestation of compliance. The Region 9 AAA reserves the right to modify or amend this policy at any time as it may deem necessary.

CERTIFICATION:
I certify that I have read the Region 9 AAA and Visions for your Community Home Health Care Agency False Claims Act Policy last reviewed October 23 2018 and hereby agree to abide by the contents of said policy.

Provider/Employee Printed Name:
_____

Provider/Employee Signature:
_____

Today's date: _____

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Previous Employer Reference Contact Form

Today's Date:_____

To whom it may concern:

The applicant named below is being considered for employment as a _____ with our company.

The applicant has listed you or your organization as a former place of employment, accordance with the release signed by the applicant below, please provide the information requested and return this form to us in the enclosed self-addressed stamped envelope.

Name of Applicant: _____

Very truly yours,

Visions for your community
Home Health Care Agency
Hiring Manager

Applicant's Authorization

I, Hereby authorize Visions for your Community Home Health Care Agency LLC, to contact my previous employer/s.

Applicant's Signature: _____

_____

STOP! ***(To be filled out by previous employer)*** ***STOP!***

Record of Employment

Date(s) of Employment:_____
Position(s) Held:_____
Reason Employment Ended:

Please rate the applicant in each of the following areas:

Job Skill	Excellent	Good	Average	Below Average	Poor
Initiative	Excellent	Good	Average	Below Average	Poor
Attendance	Excellent	Good	Average	Below Average	Poor
Conduct	Excellent	Good	Average	Below Average	Poor
Would you rehire Applicant ?	YES	NO			

_____ _____ _____
Signature Title Date

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AUTHORIZATION FOR DIRECT DEPOSIT-EMPLOYEE FORM

Please print and complete **ALL** the information below.

Name:

Address:City, State, Zip code:

PLEASE ATTACH A VOIDED CHECK HERE

Name of bank: _____

Bank Account Name Holder: _____

Account Number:

9-Digit Routing Number:

Amount: (Please Select One)

$	%	Entire Paycheck

Type of Account: (Please Select One)

Checking	Savings

I, hereby authorize, Visions for your community Home Health Care Agency, LLC., to directly deposit my pay to account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee/Subcontractor Signature:_____ Date: _____