Naples Bay Home Care
8821 Tamiami Trail E
Naples, FL 34113
239-307-7730
naplesbayhomecare@outlook.com

INDEPENDENT CONTRACTOR CHECK OFF LIST

1. Biography _____
2. References _____
3. Statement of health _____
4. Drug Screening _____
5. Cough Assessment _____
6. I-9 _____
7. Copy of Social Security Card _____
8. Copy of Driver's License _____
9. Electronic Fingerprints _____
10. Affidavit of Good Moral Character _____
11. Copy of Professional License or Certificate _____
12. Copy of CPR Card _____
13. Contract _____
14. 2 hour HIV Certificate _____
15. Domestic Violence Certificate _____
16. Medication Error Prevention or Assisting with Medications Certificate _____
17. Alzheimer's Certificate _____
18. Universal Precautions Certificate _____
19. Job Description _____
20. W-9 _____
21. Receipt Registration folder _____

NAPLES BAY HOME CARE
8821 TAMIAMI TRL E
NAPLES, FL 34113
naplesbayhomecare@outlook.com

BIOGRAPHY FOR INDEPENDENT CONTRACTOR

Name _____

Address _____

Telephone # _____ Cell # _____

Social Security # _____ Date of birth _____

License or Certificate # and date(s) _____

EDUCATION List most recent schooling first, or attach resume.

SCHOOL	YEARS COMPLETED	DEGREE OR DIPLOMA	GPA OR CLASS RANK	MAJOR AREA OF STUDY

EMPLOYMENT HISTORY List most recent experience first

Employer	
Address	
Phone number	
Dates employed there	
Job title	
Immediate Supervisor	
Starting salary	
Final salary	
Reason for leaving	

Employer	
Address	
Phone number	
Dates employed there	
Job title	
Immediate Supervisor	
Starting salary	
Final salary	
Reason for leaving	

Employer	
Address	
Phone number	
Dates employed there	
Job title	
Immediate Supervisor	
Starting salary	
Final salary	
Reason for leaving	

EMPLOYEE STANDARDS OF BEHAVIOR

MISSION
To restore, promote and maintain health in the people we serve.
APPEARANCE
Present a clean, professional, well-groomed image, following dress code.
Wear identification badge in a visible place above waist level.
Smile and make eye contact when approaching a customer or co-worker.
COMMITMENT TO CO-WORKERS
Cooperate with one another. Do not undermine other people's work; praise whenever possible.
If a co-worker conflict occurs, address concerns with the co-worker first, and if there is not a satisfactory outcome, then contact your supervisor.
Be an excellent role model for co-workers.
COMMITMENT TO CUSTOMERS
Educate families about what you are doing whenever possible.
After responding to a customer's request, always ask if there is anything else you can do for them.
COMMUNICATION
Have a smile in your voice when speaking with co-workers and customers.
CONFIDENTIALITY
Ensure patient, personal, and private information is kept confidential at all times and not discussed in public areas such as hallways or elevator.
Protect privacy, dignity and modesty at all times.
EMPOWERMENT/SENSE OF OWNERSHIP
You are empowered to take responsibility, using you own judgment, without fear of retribution, to solve problems you encounter.
"That's not my job," is NOT in our vocabulary.
Take pride in your surroundings and treat your work area as if it were your own.
SAFETY
Take the time to remove obstacles and hazards.
Be aware of fire and safety procedures and report risks immediately.
It is our duty to protect each other and our customers from risk.
SERVICE RECOVERY
You are empowered to make the customer happy no matter what!
Use the following steps for service recovery:
Spot the unhappy customer
Take ownership and listen to the problem
Offer an apology
Provide solutions and follow through.

Signature:	Date:

Reference Letter

TO: _____
ADDRESS: _____
PHONE: _____

We are considering _____ for the position of _____ with our company and you were given as a reference. Below is a signed release form authorizing disclosure of the requested information. Your completion and return of this form will be appreciated.

Jane Cox PhD AAPRN
Jane Cox, PhD, AAPRN

Employment dates: _____ to _____ Eligible for rehire: Yes ____ No ____ N/A ____
Position held: _____
Reason for leaving: _____
_____

	Excellent	Good	Fair	Poor
Attendance record				
Quality of work				
Position knowledge				
Responsibility				
Personality/character				
Punctuality				
Cooperation				
Personal appearance/hygiene				
Honesty				
Initiative				

Remarks: _____
Signed: _____ Title: _____ Date: _____

Independent Contractor's Permission: I hereby authorize this company, and also authorize and request each former employee and person, firm, or corporation given as a reference to answer all questions that may be asked, and give all information that may be sought in connection with my application or concerning me or my work, habits, character, skill or my action in any transaction. I do hereby release the addressed individual(s) connected therewith, including Community Home Care, from all liability for, and damage whatsoever, incurred in furnishing such information.

Signed: _____ Date: _____

Reference Letter

TO: _____
ADDRESS: _____
PHONE: _____

We are considering _____ for the position of _____ with our company and you were given as a reference. Below is a signed release form authorizing disclosure of the requested information. Your completion and return of this form will be appreciated.

Jane Cox PhD, AAPRN
_____
Jane Cox, PhD, AAPRN

Employment dates: _____ to _____ Eligible for rehire: Yes ____ No ____ N/A ____
Position held: _____
Reason for leaving: _____
_____

	Excellent	Good	Fair	Poor
Attendance record				
Quality of work				
Position knowledge				
Responsibility				
Personality/character				
Punctuality				
Cooperation				
Personal appearance/hygiene				
Honesty				
Initiative				

Remarks: _____
Signed: _____ Title: _____ Date: _____

Independent Contractor's Permission: I hereby authorize this company, and also authorize and request each former employee and person, firm, or corporation given as a reference to answer all questions that may be asked, and give all information that may be sought in connection with my application or concerning me or my work, habits, character, skill or my action in any transaction. I do hereby release the addressed individual(s) connected therewith, including Community Home Care, from all liability for, and damage whatsoever, incurred in furnishing such information.

Signed: _____ Date: _____

Tuberculosis skin test or symptom questionnaire

Name_____

All questions must be answered.
Have you ever:

Had a history of a positive skin test? _____yes _____no

Had a chronic or recurrent cough?

Had unexplained night sweats?

Coughed or spit up blood?

Had unexpected weight loss?

Had unexplained chronic fatigue?

Have a suppressed immune system?

Traveled outside of the US in the past 12 months?
If yes, where?_____

I acknowledge that I have answered the questions correctly to the best of my knowledge.

_____ _____
Signature date

Employment Eligibility Verification

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

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

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in Section 1, or specify which acceptable documentation employees must present for Section 2 or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the Instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)

If you check Item Number 4., enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

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

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

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

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

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

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

Care Provider Background Screening Clearinghouse
Background Screening Request Form

You have applied for a position with a health care and/or service provider regulated by a specified agency in the Care Provider Background Screening Clearinghouse (Clearinghouse) that requires a fingerprint-based background check. As a health care and/or service provider regulated by a specified agency in the Clearinghouse we may conduct a search for an existing background screening result or submit a new background screening request through the Clearinghouse results website on your behalf.

In order to complete the search and/or background screening request we must collect the following information. This information is required by the Clearinghouse, the Florida Department of Law Enforcement, and the Federal Bureau of Investigation.

Please provide the following information:

Applicant Information

*First Name: _____
Middle Name: _____
*Last Name: _____
Aliases: _____
*SSN: _____
*Date of Birth: _____
*Place of Birth: _____

Demographics

*Sex: _____
*Race: _____
*Hair Color: _____
*Eye Color: _____
*Height: _____
*Weight: _____

Contact Information

*Address Line 1: _____
Address Line 2: _____
*City: _____
*State: _____
*Zip: _____
County _____
Prior States: _____
Email: _____
Phone: _____

*Denotes Required Fields

AFFIDAVIT OF GOOD MORAL CHARACTER FOR PURPOSES RELEVANT TO SECTION 400.512, F.S., STATE OF FLORIDA

(To be signed by staff who enter the homes of clients and are required to have Level 1 screening. A copy must also be kept in the provider's personnel file.)

Authority: Pursuant to s. 400.512, F.S., The agency shall require employment or contractor screening as provided in chapter 435, using the Level 1 standards for screening set forth in that chapter, for home health agency personnel; persons referred for employment by nurse registries; and persons employed by companion or homemaker services registered under s. 400.509, F.S.

STATE OF: _____
COUNTY OF: _____

Before me this day personally appeared _____
who, being duly sworn, deposes and says:

As an applicant for employment with _____,

I hereby attest to meeting the requirements for employment that I am of good moral character that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute or ordinance of another jurisdiction:

(a) Section 393.135, F.S., relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, F.S., relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, F.S., relating to abuse, neglect, or exploitation of a vulnerable adult.

(d) Section 782.04, F.S., relating to murder.

(e) Section 782.07, F.S., relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(f) Section 782.071, F.S., relating to vehicular homicide.

(g) Section 782.09, F.S., relating to killing of an unborn child by injury to the mother.

(h) Section 784.011, F.S., relating to assault, if the victim of the offense was a minor.

(i) Section 784.021, F.S., relating to aggravated assault.

(j) Section 784.03, F.S., relating to battery, if the victim of the offense was a minor.

(k) Section 784.045, F.S., relating to aggravated battery.

(l) Section 787.01, F.S., relating to kidnapping.

(m) Section 787.02, F.S., relating to false imprisonment.

(n) Section 794.011, F.S., relating to sexual battery.

(o) Former s. 794.041, F.S., relating to prohibited acts of persons in familial or custodial authority.

(p) Chapter 796, F.S., relating to prostitution.

(q) Section 798.02, F.S., relating to lewd and lascivious behavior.

(r) Chapter 800, relating to lewdness and indecent exposure.

(s) Section 806.01, F.S., relating to arson.

(t) Chapter 812, F.S., relating to theft, robbery, and related crimes, if the offense was a felony.

(u) Section 817.563, F.S., relating to fraudulent sale of controlled substances, only if the offense was a felony.

(v) Section 825.102, F.S., relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(w) Section 825.1025, F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(x) Section 825.103, F.S., relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(y) Section 826.04, F.S., relating to incest.

(z) Section 827.03, F.S., relating to child abuse, aggravated child abuse, or neglect of a child.

(aa) Section 827.04, F.S., relating to contributing to the delinquency or dependency of a child.

(bb) Former s. 827.05, F.S., relating to negligent treatment of children.

(cc) Section 827.071, F.S., relating to sexual performance by a child.

(dd) Chapter 847, F.S., relating to obscene literature.

(ee) Chapter 893, F.S., relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(ff) Section 916.0175, F.S., relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

435.03 (3), F.S., Standards must also ensure that the person:

(a) For employees or employers licensed or registered pursuant to chapter 400 or chapter 429, and for employees and employers of developmental disabilities institutions as defined in s. 393.063, intermediate care facilities for the developmentally disabled as defined in s. 400.960, and mental health treatment facilities as defined in s. 394.455, meets the requirements of this chapter.

(b) Has not committed an act that constitutes domestic violence as defined in s. 741.28, F.S.

SIGN EITHER (1) OR (2) BELOW:

(1) Under the penalties of perjury, I declare that I have read the foregoing, and the facts alleged are true to the best of my knowledge and belief.

_____
AFFIANT

(2) To the best of my knowledge and belief, my record may contain one of the foregoing disqualifying acts of offenses.

_____
AFFIANT

This person is personally known to me or produced the following identification _____.

Sworn to and subscribed before me this _____ day of _____.
Month/Year

_____
Notary Public (Type or Print Name)

Notary State Seal:

_____
Notary Public (Signature)

_____
My Commission Expires

59A-18.0081 Certified Nursing Assistant and Home Health Aide.

The certified nursing assistant (C.N.A.) and the home health aide shall:

(1) Be limited to assisting a patient in accordance with section 400.506(6)(b), F.S.;

(2) Be responsible for documenting services provided to the patient or client and for filing said documentation with the nurse registry on a regular basis. These service logs will be stored by the nurse registry in the client's file. The service logs shall include the name of the patient or client and a listing of the services provided;

(3) Be responsible for observing appearance and gross behavioral changes in the patient and reporting these changes to the patient's health care surrogate or other person designated by the patient and the nurse registry or to the responsible facility employee if staffing in a facility;

(4) Be responsible to maintain a clean, safe and healthy environment, which may include light cleaning and straightening of the bathroom, straightening the sleeping and living areas, washing the patient's dishes or laundry, and such tasks to maintain cleanliness and safety for the patient;

(5) Perform other activities as taught and documented by a registered nurse, concerning activities for a specific patient and restricted to the following:

(a) Assisting with the change of a colostomy bag, reinforcement of dressing;

(b) Assisting with the use of devices for aid in daily living such as a walker, chair or walker;

(c) Assisting with prescribed range of motion exercises;

(d) Assisting with prescribed ice cap or collar;

(e) Doing simple urine tests for sugar, acetone or albumin;

(f) Measuring and preparing special diets;

(g) Measuring intake and output of fluids; and,

(h) Measuring temperature, pulse, respiration or blood pressure.

(6) Be prohibited from changing sterile dressings, irrigating body cavities such as giving an enema, irrigating a colostomy or wound, performing gastric irrigation or enteral feeding, catheterizing a patient, administering medications, applying heat by any method, or caring for a tracheostomy tube.

(7) For every CNA, a nurse registry shall have on file a copy of the person's State of Florida certification.

(8) For every home health aide registered with the nurse registry since May 4, 2015, a nurse registry shall have on file a certificate or documentation of successful completion of at least forty hours of home health aide training, pursuant to section 400.506(6)(a), F.S., from a public vocational technical school or a non-public postsecondary career school licensed by the Commission on Independent Education, Florida Department of Education.

(9) Individuals who earn their CNA certificate in another state must contact the Florida Certified Nursing Assistant office at the Department of Health to inquire about taking the written examination prior to working as a CNA in Florida, pursuant to chapter 464, part II, F.S.

(10) Home health aides registered with the nurse registry since the effective date of this rule who complete their training in another state must provide a certificate of completion of home health aide training from a public vocational technical school or a career education school that is licensed in that state.

(11) CNAs and home health aides referred by nurse registries must maintain a current cardiopulmonary resuscitation (CPR) certification from an instructor or training provider that is approved to provide training by the American Heart Association, the American Red Cross, or the Health and Safety Institute, and that provides CPR training in which the student is required to demonstrate, in person, that he or she is able to perform cardiopulmonary resuscitation.

(12) Licensed practical nurses and registered nurses that are licensed in Florida or another state may work as home health aides. Also, persons who have completed the licensed practical nurse or registered nurse training from a public school, college, or university or a licensed nonpublic career education school or college in Florida who are not yet licensed may work as home health aides.

(13) A certified nursing assistant may work as a home health aide.

(14) C.N.A.s and home health aides referred by nurse registries may assist with self-administration of medication as described in section 400.488, F.S.

(a) Home health aides and C.N.A.s assisting with self-administered medication, as described in section 400.488, F.S., shall have received a minimum of 2 hours of training covering the following content:

1. Training shall cover state law and rule requirements with respect to the assistance with self-administration of medications in the home, procedures for assisting the resident with self-administration of medication, common medications, recognition of side effects and adverse reactions and procedures to follow when patients appear to be experiencing side effects and adverse reactions. Training must include verification that each C.N.A. and home health aide can read the prescription label and any instructions.

2. Individuals who cannot read shall not be permitted to assist with prescription medications.

(b) Documentation of training on assistance with self-administered medication from one of the following sources is acceptable:

1. Documentation of 2 hours of training in compliance with subsection 59A-8.0095(5), F.A.C., from a home health agency if the home health aide or C.N.A. previously worked for the home health agency;

2. A training certificate for assisted living facility staff in compliance with section 429.52(6), F.S.;

3. A training certificate for at least 2 hours of training from a career education school licensed pursuant to chapter 1005, F.S., and rule division 6E, F.A.C., by the Department of Education, Commission for Independent Education;

4. Documentation of at least 2 hours of training by a provider approved by the Florida Board of Nursing, Department of Health.

(c) Documentation of the training must be maintained in the file of each home health aide and C.N.A. who assists patients with self-administered medication.

(d) In cases where a home health aide or a C.N.A. will provide assistance with self-administered medications as described in section 400.488, F.S., and paragraph (e) below, a review of the medications for which assistance is to be provided shall be conducted by a registered nurse or licensed practical nurse to ensure the C.N.A. and home health aide are able to assist in accordance with their training and with the medication prescription and the medication is not required to be administered by a nurse. If the patient will not consent to a visit by the nurse to review the medications, a written list with the dosage, frequency and route of administration shall be provided by the patient or the patient's health care surrogate, family member, or person designated by the patient to the home health aide or CNA to have reviewed by the nurse. The patient or the patient's surrogate, guardian, or attorney in fact must give written consent for a home health aide or C.N.A. to provide assistance with self-administered medications, as required in section 400.488(2), F.S.

(e) The trained home health aide and C.N.A. may also provide the following assistance with self-administered medication, as needed by the patient and as described in section 400.488, F.S.:

1. Prepare necessary items such as juice, water, cups, or spoons to assist the patient in the self-administration of medication.

2. Open and close the medication container or tear the foil of prepackaged medications,

3. Assist the resident in the self-administration process. Examples of such assistance include the steadying of the arm, hand, or other parts of the patient's body so as to allow the self-administration of medication,

4. Assist the patient by placing unused doses of solid medication back into the medication container.

(15) The nurse registry is not obligated to monitor, manage or supervise a certified nursing assistant or home health aide pursuant to section 400.506(19), F.S. The nurse registry is not obligated to review patient or client records per section 400.506(20), F.S., but the nurse registry is not prohibited from reviewing records and may do so. In the event of violation of section 400.488, F.S., or other state laws that comes to the attention of the nurse registry, the nurse registry shall take the actions specified in section 400.506(19), F.S.

Rulemaking Authority 400.488, 400.497, 400.506 FS. Law Implemented 400.488, 400.497, 400.506 FS. History–New 1-27-94, Amended 12-24-00, 9-10-06, 2-15-07, 5-4-15, 2-2-16.

Signature

Date

Naples Bay Home Care, LLC, Provider Referral Agreement

The Provider referral agreement (this "Agreement") is made effective this _____ day of _____, 20___ by and between **Naples Bay Home Care, LLC,** ("Company") and _____, a companion, home health aide, skilled nursing service provider or housecleaner ("Provider"). In consideration of the mutual obligations set forth below, the parties agree as follows:

1. **Referral service.** The Company is a referral service that refers homemaker, companion, home health aide or skilled nursing service providers to individuals who have contracted the Company in need of such a referral (which are referred to in this Agreement as "Client(s)").

2. **Provider.** Provider is a homemaker, companion, home health aide, skilled nursing or housecleaning provider who is an independent contractor and desires to be registered with the Company for purposes of obtaining referrals to Clients. Provider represents that he or she is qualified to perform homemaker, companion, home health aide, or skilled nursing (registered nurse or licensed practical nurse) services for Clients. Provider does not require any training from the Company other than orientation to Company 's referral process, internal practices, or as may be require by law. Provider also represents that Provider has not been found guilty or otherwise convicted of a disqualifying offense.

3. **Registration.** Company hereby registers Provider with the Company as a homemaker, companion, home health aide, skilled nursing service or housecleaning providers. Provider hereby engages the Company to act as a referral service of Clients for Provider's benefit. Provider understands that the Company is not guaranteeing that any referrals will be made. Provider may decline any referrals that may be made by Company. The Company has complete discretion in making referrals.

4. **Adherence to Company's Policies, Rules and Regulations.** Provider shall comply with Company's anti-harassment and anti-discrimination policies and any safety policies while at the Company's property or when interacting with the Company personnel whether in force or hereafter adopted and amended. The Company complies with civil rights requirements pursuant to Chapter 760, F.S.

5. **Conduct.** Provider shall conduct all business in a reputable manner and shall comply with all applicable Federal, state, and local laws, rules, and regulations, ethical standards, FDLE screening, and licensing requirements, and shall perform in a manner consistent with generally-accepted procedures for that profession. Provider understands the legal limitations on Provider's services and will act only within those limitations. Provider acknowledges Provider's obligation to keep abreast of all legal and other issues which affect the companion service provider industry as they may change from time to time. Provider will not unlawfully discriminate against any individual associated with the performance of the services.

6. Services. In the event a referral by the Company ("Referral") results in Provider providing services for a Client, Provider will ensure that Provider and the Client have first reached an agreement on the details of the Provider services to the Client ("Services") and the terms of their relationship. The Services will be performed directly for client, and not for the Company, Provider will report to the Client regarding the Services.

7. Notice of Problems and Cooperation. To assist in future referrals, Provider shall advise the Company of any problems, complains or concerns relating to Client care, security, safety, accidents, thefts, violations of law or policy, relating to this Agreement as soon as possible under the circumstances. Provider shall cooperate in any investigation or inquiry initiated by the Company.

8. Liability for Injuries and Damages. Provider is responsible for any injuries to Provider and for any damages caused by Provider. Provider accepts all responsibility for maintaining sufficient insurance to cover Provider in the event of injury or damage. Provider agrees that in the event Provider is injured or damaged in any way, Provider will not sue, and hereby waives and releases, any and all claims Provider may have at any time in the future against the Company or its insurers, agents, assigns, officers, directors, shareholders or employees. Provider agrees that in the event Provider is injured or damaged due to the alleged acts, including recklessness or negligence of the client or a third party, Provider will not sue, and hereby waives and releases, any and all claims Provider may have at any time in the future against Company, Client or the Client's insurers, agents, heirs, estate or assigns.

9. Insurance & Responsibility. Provider is responsible for all Providers' interactions relating to this Agreement. The Company will not provide insurance for Provider.

10. Indemnification. To the extent permitted by law, Provider shall indemnify the Company for any and all damages, liabilities, costs, and expenses (including, but not limited to attorney's fees') reasonably incurred by or awarded against the Company which relate to a claim to a proceeding against the Company based on negligent or wrongful conduct of Provider (each, a "Claim"). This indemnification is effective only if (i) the Company promptly notifies Provider in writing of any known Claim, whether threatened or actual (or Provider is not materially prejudiced by failure to receive prompt written notice of such Claim), (ii) the company fully cooperates with Provider (at Provider's expense) in the defense of any such Claim, (iii) Provider controls the defense against any such Claim, unless the interests of the parties materially differ or Provider's counsel is not reasonably acceptable to the Company, and (iv) the Company's damages, liabilities costs, and expenses are not paid by insurance or otherwise covered by third party. This provision shall survive the termination of this Agreement.

11. Subagents and Employees. Provider shall not provide services to Clients of the Company through any subagent or employee of Provider unless the subagent or employee is registered with the Company and is subject to a separate referral agreement between said subagent or employee and Company. Provider shall be solely responsible for the hiring, compensation, termination, and all other matters relating to any persons, or entities employed

by Provider for any reason whatsoever. Provider hereby indemnifies the Company against any injuries, actions, or proceedings of any kind arising from the appointment of such persons or entities.

12. Non-disclosure. Except to the extent required by law, Provider shall never disclose, even after the termination of this Agreement, to anyone of the following: Client lists, Provider lists, job costs, supplier's relationships, and any other information which pertains to the operation of the business of the Company.

13. Waver of Employment Status & Benefits. In entering into this Agreement with Company, Provider acknowledges that Provider will not become an employee of the Company. However, regardless of how the legal status of Provider's relationship with the Company may be characterized, Provider acknowledges and agrees that the Company will not provide to Provider or to anyone on Provider's behalf, any compensation, taxes , insurance, or benefits, including without limitation, life, health and dental insurance, vacation, sick and other paid time off, ERISA and non-ERISA plans, retirement plans and programs, workers' compensation insurance, unemployment insurance, and any benefits that may currently or in the future be provided to all or some portion of the Company's employees. The Provider is responsible for payment of self-employment taxes.

14. Working Facilities. Provider shall work primarily from Client's home or other premises as requested by Client, Provider shall utilize Provider's own equipment or equipment provided by Client.

15. Expenses; Disbursements. In the event Provider advances funds to a Client at the Client's request, and the Client fails to repay the expense, the Company will have no responsibility for payment or collection of such amounts, but will agree to list the amount on the bill sent to the Client. Any such amounts must have been approved in advance by the Client. Provider is responsible for all expenses incurred and disbursements made by Provider as a companion service provider, including the payment of any permits and licenses, and home and car telephone costs. Provider shall have no right to incur any liability for expenses and disbursements of any account of the Company and Provider shall indemnify the Company in relation thereto. The Company shall have no obligation to either the Client or Provider regarding expenses, liabilities, or the Services.

16. Schedule. Provider shall perform services when reasonable and as appropriate under the circumstances and pursuant to the client's needs. The Company shall not subject Provider to a specific schedule.

17. Authority. Provider shall not have the authority to enter into contracts binding upon Company or to create debts or obligations on behalf of Company.

18. Independent Professional Judgment. Nothing contained herein is intended to interfere with the exercise of independent professional judgment by Provider.

19. **Referral and Service Fee.** Whenever Provider is engaged to perform service of any kind and in any capacity, whether as an independent contractor under this Agreement or as an employee of Client or otherwise, Provider shall pay a referral fee ("Referral Fee") to the Company, which shall be determined as follows:

a) Provider agrees that the Company shall negotiate with each Client a schedule of rates for the Services (the "Agreed Rate"). As part of any referral, the Agreed rate will be disclosed to Provider, who may accept or refuse the referral. Acceptance of the referral constitutes Provider's agreement to perform the Services for the Agreed Rate less the fee paid to the Company (Referral Fee"). A Client may reject a Provider at any time and will owe a Provider for Services not yet performed.

b) In the event that Provider is engaged by a Client, notwithstanding anything to the contrary appearing in this Agreement, this Agreement shall continue until such time as there shall be no services of any kind provided by Provider to a Client referred to Provider by the Company for a period of **270** days after the termination of this Agreement of any extension hereof. This Agreement shall be deemed automatically reinstated and shall continue until such time as there shall be no services provided by Provider to a Client referred to Provider by the Company for a period of **270** days, and Provider agrees to pay the Company the referral fee set forth in this Agreement. If a client hires a Provider directly, the Provider will be responsible for paying the Company, the Referral Fee. If the Provider obtains additional work through any Client of the Company, the Provider will pay the Company the referral fee in the same manner and amount as if the Provider were working for a Client of the Company.

20. **Collection of Fees.** In the event the Client delivers the Referral Fee to the Provider, Provider shall immediately pay the Referral Fee to the Company. To facilitate payment of the Referral Fee due to the Company from the Client, Provider authorizes the Company to invoice any Client for the Referral fee. In the event a Client makes payment of all fees based upon the Agreed Rate directly to the company, the Company will deduct the Referral Fee and pay the Service Fee to Provider.

21. **Amount of Fees.** At the time of this Agreement, the current fees are listed at Exhibit A; however, the fees are subject to change at any time at the discretion of the Company.

22. **Independent Contractor.** Each party shall be regarded as an independent contractor for all purposes, including, without limitation, income tax and employment tax purposes, shall represent such status to third parties. Independent contractor is responsible for payment of self-employment estimated taxes. Neither party shall withhold any portion of the other's compensation for income, employment, or other tax purposes, and the Company shall furnish Provider with a form 1099 only when required. Neither party shall provide health, workman's compensation, or unemployment insurance, or any other benefits to the other. This Agreement shall not make either party an employee, partner, joint venture or with the other, and neither

party shall bind or transact business in the other's name, or make representations or commitments on the other's behalf without prior written approval.

23. Term. Unless earlier terminated or extended pursuant to its terms, this Agreement shall be effective on the Effective Date and shall continue through _____, 20____. Provider or the Company may terminate this Agreement upon giving written notice to the other party of the intention to terminate. Termination shall be without prejudice to the rights and obligations of the parties that have vested prior to the effective date of termination and shall have no impact on the continuing obligations, including confidentially, non-competition, amounts owed, refund fees, and billing.

24. Attorneys Fees. In the event of litigation relating to this Agreement or relationship, including provision of services to clients, the prevailing party shall be entitled to recover all costs, whether or not suit is filed, and costs of any litigation that results there from, including reasonable attorneys' fees for all proceedings, trials and appeals.

25. Assignment. This Agreement may not be assigned or otherwise transferred by Provider. The provisions of this Agreement shall insure to the benefit of the Company and Company's successors and assigns. This Agreement may be assigned by the Company to any person or entity which purchases all or substantially all of the assets of Company, without the consent of Provider.

26. Severability. Each provision of this Agreement shall be treated as severable such that any provision shall be determined to be unenforceable; the balance of the Agreement shall remain in full force and be interpreted as if that unenforceable provision had never been contained in the Agreement.

27. No wavier. The failure of any party to insist upon strict performance of any obligation hereunder shall not be a waiver of such party's right to demand strict compliance of that or any other obligation in the future. No custom or practice of the parties at variance with the terms of this Agreement shall constitute a waiver, nor shall any delay or omission of a party to exercise any rights arising from a default impair the party's right as to the default or to any subsequent default.

28. Other Agreements. This Agreement supersedes all previous agreements and understandings between the Company and Provider, whether oral or written, to the extent they are inconsistent with Agreement. Agreements dated prior to the execution of this Agreement between Provider and the Company is hereby amended to conform to this Agreement.

29. Amendment. No change, alteration, modification, or addition to this Agreement shall be effective unless in writing and properly executed by both parties.

30. Applicable law. This Agreement and any disputes relating thereto shall be governed by the internal laws of the state of Florida and the court's venue shall be in Collier County.

31. Entire Agreement. This Agreement constitutes the entire agreement the Company and Provider and the Company and Provider acknowledge and agree that neither of them has made any representation with respect to the subject matter of this Agreement or any representations including the execution and delivery hereof except as specially set forth here. The Company and Provider acknowledge that he or she or it have relied on his or her own or its own judgment in entering into the same.

The parties hereto have set their hands and seals the day and year first set forth above.

Provider: _____
Signature

Print Name: _____

_____

BY: _____
Signature

Print Name: _____

As Its: President
COMPANY: NAPLES BAY HOME CARE, LLC

a Florida Corporation

POLICY FOR PREVENTION OF HIV (AIDS) AND HBV (HEPATITIS B VIRUS)

UNIVERSAL PRECAUTIONS

In compliance with the Centers for Disease Control, we requires all healthcare workers to follow Universal Blood and Body Fluid precautions in caring for all patients. Universal Precautions include the following:

1. Gloves must be worn during patient care contacts which could expose the caregiver to blood, body fluids, secretions or excretions during bathing, linen change, cleaning of urine, semen, feces, vomits, per-care, oral care, wound care, suctioning, and taking temperatures. Gloves should be discarded in plastic bags that are sealed and discarded with other household garbage. If these items are contaminated with blood, they are bagged in thick sealed red bags labeled with the International Biological Hazard Symbol. Hands must be washed thoroughly immediately following removal of gloves.

1. All healthcare workers should take extreme precautions to prevent injuries caused by needles, lancets, and other sharp instruments hereafter referred to as "sharps". To prevent needle stick injuries, needles must not be re-capped, purposely bent or broken by hand, removed from disposable syringes. or otherwise manipulated by hand. All used sharps must be placed in puncture-resistant containers which are placed as close as possible to the point of use. These are labeled "Biohazard Infectious Waste" and are supplied by and returned to Naples Bay Home Care for biomedical waste disposal.

1. Any accidental needle stick, splashing of blood or other body fluids in eyes, mucous membranes, or other exposed body areas which may have open cuts or wounds are to be reported immediately to the office, and an incident report completed. Employees will then be referred to the HRS Collier County Public Health Unit for follow up.

1. In the event of an accident spill of blood or body fluids, the area should be diluted with hot tap water and then a hypochlorite solution applied for at least three (3) minutes. This is made by combining one (1) cup chlorine bleach with one (1) gallon of hot water. The area should be cleaned with disposable towels: put used towels in a red bag. Gloves must be worn doing this. Hands must be washed following removal of gloves.

I have read and understand the policies on Universal Precautions and Biohazardous Waste Management and acknowledge that I have received a copy of this document.

SIGNATURE: _____ DATE: _____

JOB DESCRIPTION-REGISTERED NURSE and LICENSED PRACTICAL NURSE

RESPONSIBLE TO: NURSING SUPERVISOR

QUALIFICATIONS:

1) **MUST HAVE A CURRENT LICENSE AS A REGISTERED NURSE OR LICENSED PRACTICAL NURSE IN THE STATE OF FLORIDA.**
2) **MUST BE ABLE TO READ WRITE AND SPEAK ENGLISH.**
3) **MUST HAVE A VALID DRIVER'S LICENSE & PROOF OF AUTOMOBILE LIABILITY INSURANCE.**
4) **A MINIMUM OF ONE YEAR OF EXPERIENCE AS A REGISTERED NURSE OR LICENSED PRACTICAL NURSE IN A APPLICABLE SPECIALTY AREA.**
5) **CURRENT C.P.R. CERTIFICATION.**

59A-18.007 Registered Nurse and Licensed Practical Nurse.
The registered nurse and the licensed practical nurse shall:
(1) Be responsible for the clinical records for their patients. The clinical records shall be filed with the nurse registry, for each patient or client to whom they are giving care in the home or place of residence or when they assess the care being provided by non-licensed independent contractors, pursuant to Section 400.506(10)(c), F.S. Clinical notes and clinical records related to care given under a staffing arrangement are maintained by the facility where the staffing contract is arranged;
(2) Be responsible for maintaining the medical plan of treatment with clinical notes and filing the initial medical plan of treatment, any amendments to the plan, any additional order or change in orders, and a copy of the clinical notes at the office of the nurse registry;
(3) The licensed practical nurse shall be under the direction of a registered nurse, or a physician licensed pursuant to Florida Statutes, as required under Section 464.003(3)(b), F.S.
Specific Authority 400.497, 400.506 FS. Law Implemented 400.497, 400.506 FS. History–New 2-9-93, Amended 1-27-94, 12-24-00.

I HAVE READ AND UNDERSTOOD THE ABOVE JOB DESCRIPTION

SIGNATURE _____ DATE _____

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ - ___ - ____

or

Employer identification number

__ - _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person ▶ Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

NURSINGNETWORK of NAPLES, Inc.
8813 Tamiami Trl E. Naples, FL 34113

Receipt of Independent Contractor Registration Folder

I have received a copy of the Independent Contractor Registration Folder, a copy of my job description and resources for Alzheimers and Related Dementias information.

_____Signature_____Date