



REQUEST FOR CRIMINAL HISTORY CHECK

Based on Chapter 250 of the Health and Safety Code, this facility is required to conduct a criminal history check on all potential employees who are employed in direct contact with a resident in our facility. This check must be initiated within 24 hours of employment and identifying information will be submitted electronically to the Texas Department of Public Safety to obtain the potential employee's criminal conviction record. In addition, if we have reason to believe, based on your application or documents presented, you have lived/worked out of the state of Texas we will run a national/international criminal history check. The facility may repeat this procedure at any time in the future, as they deem appropriate. It is understood that this is privileged information and is for exclusive use of this facility. The facility may not employ a person if the facility determines, as a result of the criminal history check, that a person has been convicted of an offense listed in Chapter 250 that bars employment or that a conviction is a contraindication to employment with the residents the facility serves. If you do become employed at this facility and are convicted of an offense that would preclude employment in a nursing facility and/or are excluded from participation in any Federal/State health care program after your hire date, you must report this immediately to the Administrator of this facility. In order to conduct this check, the applicant must provide at least the following "identifying information":

(1) Complete name: _____
(First) (Middle) (Last)

(2) Maiden name and/or other names you go by: _____

(3) Date of birth: _____

(4) Social security number: _____

I have read the above statement and understand these requirements.

Employee Signature: _____ **Date** _____

Employee Printed Name: _____



DPS Computerized Criminal History (CCH) Verification
(FACILITY COPY)

I, _____, have been notified that a Computerized Criminal
APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) check may be performed by accessing the Texas Department of Public Safety Secure Website and may be based on name and DOB identifiers. (This is not a consent form, but serves as information for the applicant.) Authority for this agency for access to individual's criminal history data may be found in Texas Government code 441; Subchapter F.

Name-based information is not an exact search and only fingerprint records searches represent true identification to criminal history record information (CHRI), therefore the organization conducting the criminal history check is not allowed to discuss with me any CHRI obtained using the name and DOB method. The agency may request that I also have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

In order to complete the fingerprint process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at https://www.dps.texas.gov/internetforms/Forms/CR-68.pdf or by calling the DPS Program Vendor at 1-888-467-2080, and submit a full and complete set of fingerprints, request a copy to the agency listed below, and pay a fee of \$25.00 to the fingerprinting services company.

Once this process is complete the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by this facility. Required for future DPS Audits)

Form with two columns: Left column for signatures and dates; Right column for 'Check and Initial each Applicable Space' including CCH Report Printed, Purpose of CCH, Empl/Vol/Contractor, Date Printed, and Destroyed Date. Includes 'Retain in Facility Files' instruction.

TAC Chapter 93-EMPLOYEE MISCONDUCT REGISTRY (EMR) REQUIREMENTS

Before a facility may hire a person, the facility must check the Employee Misconduct Registry (EMR) and the Nurse Aide Registry (maintained under the Omnibus Budget Reconciliation Act of 1987) to see if the person is listed as unemployable.

Facilities are prohibited from employing a person who is listed in either agency as having abused, neglected, or exploited a resident or consumer of a facility or individual receiving services from an agency.

Each facility is required to provide information about the EMR to all employees. The information must: (a) be in writing; and (b) state that persons listed on the EMR are not employable.

If the Department of Aging and Disability Services (DADS) receives a report that an employee of a facility committed reportable conduct, DADS will investigate the report to determine whether the employee has committed the reportable conduct. The standards for abuse, neglect, exploitation, and misappropriation that apply to these investigations are the standards that apply to the type of facility where the investigation takes place.

DADS will give written notice to an employee alleged to have committed an act of reportable conduct that will include the following items and must state:

- (1) a brief summary of the findings and facts on which the findings are based;
- (2) the employee's rights to an informal review (IR) to dispute the findings;
- (3) a notification that the request for an IR must be made no later than 10 days after the day the employee receives the written notice. This written notice to the employee provides the address and contact information for the local DADS regional office; and a statement of the right of the employee to judicial review of the order; and
- (4) that persons listed on the EMR are not employable.

If the employee does not request an informal appeal contesting the finding of an act of reportable conduct, DADS will record the incident of reportable conduct in the EMR.

If an employee commits reportable conduct, the Texas Department of Aging and Disability Services (DADS) will record the following information:

- (a) the employee's name;
- (b) the employee's address;
- (c) the employee's social security number;
- (d) the name of the facility
- (e) the address of the facility
- (f) the date of the act of misconduct; and
- (g) a description of the act of misconduct.

Employee Signature: _____ **Date** _____

Employee Printed Name: _____

EMPLOYEE MISCONDUCT POLICY

Before a facility may hire a person, the facility must check the Employee Misconduct Registry (EMR) and the Nurse Aide Registry (maintained under the Omnibus Budget Reconciliation Act of 1987) to see if the person is listed as unemployable.

Facilities are prohibited from employing a person who is listed in either agency as having abused, neglected, or exploited a resident or consumer of a facility or individual receiving services from an agency.

Each facility is required to provide information about the EMR to all employees. The information must:

- (1) be in writing; and
- (2) state that persons listed on the EMR are not employable.

EMPLOYEE MISCONDUCT PROCEDURE

1. Before hiring an employee, form HR104A will be signed by the potential employee acknowledging notification of an Employee Misconduct Registry check and requirements.
2. Verification that the Nurse Aide Registry and Employee Misconduct Registry has been searched prior to employment will be documented on this form with the findings attached.
3. Verification will become part of the pre-employment process.

FOR OFFICE USE ONLY VERIFICATION OF SEARCH 1-800-452-3934

Nurse Aide Registry: _____ Employee Misconduct Registry: _____

Date: _____ Date: _____

Facility Employee _____ Facility Employee _____

Signature: _____ Signature: _____

Comments:

FOR OFFICE USE ONLY

OIG/Medicaid Participation/Exclusion Program

Name/Contractor: _____

Signature: _____

Date Verified: _____

Excluded: YES ____ NO ____

The above person has applied for employment at this facility or has been contracted to perform services at this facility or is a vendor who serves this facility. This individual or entity has been checked through the OIG's and Medicaid's List of Excluded Individuals/Entities and has not been excluded from participation in any Federal or State health care program.

Note: If the above entity or individual appears on the exclusion list, the administrator is to be notified immediately.

Facility Representative: _____

Date: _____

Mandatory Coronavirus (Covid-19) Vaccination Policy 2022

Caraday Healthcare recognizes its responsibility under the new CMS Vaccine requirement to provide to you, as team members, a workplace free of recognized hazards and to help safeguard the health and well-being of our team members and their families as well as our residents. As a condition and term of employment, all Caraday Healthcare team members must receive the most effective Coronavirus (“**Covid-19**”) vaccine available to you that has been approved by the FDA (for emergency use or otherwise) ***unless you receive an approved exception as described below***. For those team members that do not have an approved exception, you must receive the following:

- Phase 1- 1st dose or one-dose vaccine by February 21, 2022, or, have a pending request for, or have been granted a qualifying exemption.
- Phase 2- All Team Members are fully vaccinated by March 21, 2022 or have a pending request for, or have been granted a qualifying exemption.

Exception Details:

For team members claiming an exception, please submit the attached Covid-19 Vaccination Exception Form to HR immediately if you need an exception due to disability, medical reasons, or a sincerely held religious belief. Specifically, to assist any team members who are disabled and/or may have a qualifying medical condition that contraindicates a vaccination, you must include supporting medical documentation with your Covid-19 Vaccination Exception Form. The supporting medical documentation must be signed and dated by a licensed practitioner who is acting within their respective scope of practice. The CDC has a limited set of recognized medical contraindications.

If you decline a vaccination because it conflicts with your sincerely held religious beliefs, you must complete the Covid-19 Vaccination Exception Form and indicate the vaccination is being declined due to religious reasons. You should also write a letter explaining the nature of the religious belief(s), practice(s), and accommodation requested.

Exception requests will be evaluated individually on a case-by-case basis within a reasonable period of time by the Company.

Requirements Upon Receiving Exception:

If an exception is granted, you must still always wear a mask and goggles and try to stay at least six (6) feet away from other team members and residents when not assisting with care.

Compliance:

Any person covered by this policy who fails to comply with the Company’s vaccination requirements and is not granted an exception may be subject to disciplinary action including, without limitation, being placed on unpaid leave, and/or the ending of employment as permitted by applicable law. Caraday Healthcare will continue to monitor the CMS vaccine requirement for any updates to the mandate including any delays in the timeline and Caraday reserves the right to re-evaluate our internal policy accordingly.



Covid-19 Vaccination Exception Form

I am requesting an exception to the Covid-19 for the following reason(s) checked below:

- My philosophical or religious beliefs prohibit me from receiving a vaccination. **Please provide details, including the nature of the objection, why complying with the COVID-19 vaccination burdens your religious exercise, and how long you have held the religious belief underlying your objection.**

- Medical (medical contraindication) or disability reasons prohibit me from receiving a vaccination. **Please provide medical documentation.**

Please be aware that the submission of this form does not guarantee that Caraday Healthcare can provide an accommodation and such decisions will be evaluated on an individualized basis. With your signature below, you represent that the information you are submitting and your request above are true and correct. You understand and agree that any falsified information can result in disciplinary action up to and including the ending of employment.

Print Name: _____ Location: _____

Signature: _____ Date: _____

If this form is submitted, please send to the Resource Center HR for review along with the supporting documentation at humanresources@caradayhealth.com.