

DOCUMENTS REQUIRED: RN/LPN, and Professional Staff



1. State of Florida License
2. Proof of Liability Insurance
3. CPR Card
4. HIV/AIDS Certificate (ORIGINAL 4 hrs and Update)
5. OSHA Certificate (Update)
6. Domestic Violence Certificate
7. Driver License
8. Auto Insurance
9. Proof of Citizenship/Residency (Voter registration, Resident Card, etc)
10. Social Security Card
11. Physical Examination (less than six (6) months or new request)
12. Criminal Background check (less than 2 years, or 1 money order for \$ 23.00)

Home Care USA, Inc.

Employee Name:



## JOB DESCRIPTION SPEECH THERAPIST

Our agency hereby approves that we shall hire a Speech Therapist, indicated for dysphasia and dysphagia, whose tenure of office shall be governed by the following rules:

1. He/she must be a graduate of an approved school for Speech Pathologists.
2. He/she must be licensed by the state -- the license must be current.

Responsibilities of the Speech Pathologist shall include but, not limited to the following:

- a. He/she shall assist the Physician, **physician assistant, or advanced registered nurse practitioner** in evaluating a patient determine the type of speech or language disorder and the appropriate corrective therapy.
- b. He/she shall provide rehabilitative services for speech and language disorders.
- c. He/she shall record activities and findings in the clinical record and shall report to the physician, **physician assistant, or advanced registered nurse practitioner**, the patient's reaction to treatment and any changes in the patient's condition, **or when there are deviations from the plan of care.**
- d. He/she shall instruct other health team personnel and family members of patients in methods of assisting the patient to correct speech disabilities.
- e. Ensure HIPAA guidelines and procedures are maintained.

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Administrator

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Employee

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Date

# ORIENTATION CHECKLIST: PROFESSIONAL STAFF

Employee Name: \_\_\_\_\_

## I. GENERAL ORIENTATION

- \_\_\_\_\_ AGENCY ORGANIZATIONAL STRUCTURE
- \_\_\_\_\_ PHILOSOPHY, GOAL & OBJECTIVES, MISSION
- \_\_\_\_\_ TOUR OF FACILITY
  - a) LOCATION OF ADMINISTRATIVE OFFICES
  - b) LOCATION OF EMERGENCY LIGHTS/EXITS
  - c) LOCATION OF FIRE EXTINGUISHERS
  - d) LOCATION OF FIRST AIDE BOX
  - e) EMERGENCY EVACUATION ROUTES
- \_\_\_\_\_ INTRODUCTION TO STAFF/CLIENTS
- \_\_\_\_\_ SCOPE OF SERVICES
- \_\_\_\_\_ EMPLOYMENT POLICIES/JOB DESCRIPTION
- \_\_\_\_\_ COMPLAINTS POLICY/GRIEVANCE FORM
- \_\_\_\_\_ PAYROLL
- \_\_\_\_\_ CORPORATE COMPLIANCE PLAN



## II. CLINICAL ORIENTATION

- \_\_\_\_\_ CLIENT RIGHTS AND RESPONSIBILITIES
- \_\_\_\_\_ ADMISSION/DISCHARGE CRITERIA/THERAPY SERVICES
- \_\_\_\_\_ MEDICAL EMERGENCIES
- \_\_\_\_\_ PSYCHIATRIC EMERGENCIES
- \_\_\_\_\_ DOCUMENTATION REQUIREMENTS/TIME FRAMES
- \_\_\_\_\_ CLINICAL RECORDS

## III. CONFIDENTIALITY/HIPAA GUIDELINES

- \_\_\_\_\_ CLIENT/FAMILY/SIGNIFICANT OTHER
- \_\_\_\_\_ PROGRAM/STAFF
- \_\_\_\_\_ INFORMATION

## IV. SAFETY/RISK MANAGEMENT/INFECTION CONTROL

- \_\_\_\_\_ ACCIDENTAL/INCIDENT REPORTING
- \_\_\_\_\_ OSHA
- \_\_\_\_\_ UNIVERSAL PRECAUTION
- \_\_\_\_\_ BIOHAZARDOUS/INFECTION WASTE
- \_\_\_\_\_ HIV UPDATE
- \_\_\_\_\_ TB UPDATE
- \_\_\_\_\_ EMERGENCY PREPAREDNESS
- \_\_\_\_\_ FIRE DRILL
- \_\_\_\_\_ CARE OF ENVIRONMENT

I HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF THE AGENCY AND HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY QUESTIONS/CONCERNS ADDRESSED TO MY COMPLETE SATISFACTION.

I AGREE TO ABIDE AND UPHOLD ALL POLICIES AND PROCEDURE, AND HAVE BEEN ADVISE THAT FAILURE TO DO SO MAY RESULT IN TERMINATION OF EMPLOYMENT.

I ALSO AGREE THAT AS A CONDITION OF EMPLOYMENT THAT I WILL PROVIDE THE AGENCY WITH A FOURTEEN (14) DAY WRITTEN NOTICE OF INTENT TO TERMINATE EMPLOYMENT.

\_\_\_\_\_  
EMPLOYEE SIGNATURE/TITLE

\_\_\_\_\_  
DATE



## SPEECH THERAPY COMPETENCY (page 1)

Name: \_\_\_\_\_

TASKS/BEHAVIORS COMPLETED	DATE PERFORMED OR COMPETENT	INITIALS OF EMPLOYEE OR CONTRACTOR	COMMENTS
Referral process			
ASSESSMENT OF:			
Level of Function			
Physical Assessment			
Expressive Language			
Receptive Language			
Cognitive Language			
Articulation			
Oral Motor Exam			
Voice/Laryngeal			
Swallowing/Deglutition			
Appropriate development of the plan of care			
Coordination of care with appropriate disciplines			
Physician Notification			
Discharge plan discussed with patient on admission/Review of all Literature			
Communication with PCC/Case Manager			

TASKS/BEHAVIORS COMPLETED	DATE PERFORMED OR COMPETENT	INITIALS OF EMPLOYEE OR CONTRACTOR	COMMENTS
Timely paperwork submission/review of Regulations			
Timely notification for patient visits/use of calendar			
All paperwork due by the last day of the month by 5pm or by 8:30 am the Monday after the last day of the month to process billing.			
Review of documentation/revisit			
Review of documentation admission			
Notification of patient of discharge 2 wks prior & document			
Evaluation for additional services			
COMMENTS			

Home Care USA, Inc.

SIGNATURE OF ORIENTEE \_\_\_\_\_

SIGNATURE OF PRECEPTOR \_\_\_\_\_

