

Application Instructions:

Please find enclosed the instructions and information about our service and procedures. Please complete, sign and return six (6) documents pages over internet, fax (1-888-301-ICON (1-888-301-4266)) or US Postal Service.

You must be the actual person in need of home care assistance or the Power of Attorney (here-in described as the "client") to sign these six (6) documents listed as follows:

1. Completed Job Description Form with Signature of Patient or Power of Attorney. Please make sure that you include: **The Name, phone number, address of the physician and any institutions responsible for the client's care during the past year and all emergency contact information. Thoroughly describe the client's current mental, physical and mobility status.**
2. Signed HIPPA Policy Notice
3. Signed Advanced Directive Notice
4. Signed Patient's Bill of Rights
5. Signed Service Agreement. We require our services to be prepaid two (2) weeks in advance The 2 weeks' deposit will be used towards the last two weeks of service and will be credited to your account. (**For example** live-in help, the security deposit based on \$450/daily rate x 7 days x 2 weeks = \$6,300.)
6. Automatic Payments Agreement.

In addition, please provide us with a copy of the following documentation:

Please have those original documents ready for our RN to review during first assessment visit.

A. Copy of Advance Directives (Living will, if applicable).

B. Copy of Power of Attorney.

C. Client's past and present medical history (RN's evaluations, doctors diagnosis, discharge information, medication schedule etc.)

As soon as we receive these documents, we will return the original Power of Attorney to you, have our Registered Nurse review your documents, and call you to schedule an appointment for the initial assessment.

Costs for providing home care services are as follows:

Our Rates Vary Depending on Scope of Work and Experience of Caregiver but are not less than:

\$45/hour for hourly

\$450/day for live-in

Plus \$100 mandatory one time application processing fee.

RN follow up visitation costs included.

Time and a half overtime rates apply if the same CHHA is requested to work over 40 hours per week.

About us:

ICONNEL stands for high quality standards in Home Health Care Services, originally in-cepted as **White Glove Intercare, Inc.** which has been in business since April 30, 1992. The business name may have changed, but the owners remain the same. The intent of the creation of this enterprise is to concentrate on providing nationwide Certified Homemaker Home Health Aide services.

ICONNEL is USA Licensed Personnel Service started in the heart of New Jersey's Polish community, with an outstanding reputation in the New Jersey Health Care Industry. We are constantly working on improving the quality and range of our services.

Our constant awareness of the needs of our clients makes our service more personal from our office staff to our field employees.

Please feel free to call our office at **1-800-915-ICON (1-800-915-4266)** if you have any questions.



ICONNEL

246 West 38th St. 10th Floor
NY, NY 10018

Tel: 1-800-915-ICON
(1-800-915-4266)

Fax: 1-888-301-ICON
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info@ICONNEL.com
<http://www.ICONNEL.com>

Application Instructions: 1. Job Description Intake Form



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Client' Date of Birth: _____ Social Security #: _____

Client's Name _____

Name of Power of Attorney _____

Street Address _____

Relationship to the Client _____

City _____ State _____ Zip Code _____

Street Address _____

Phone # _____

City _____ State _____ Zip Code _____

Others at Client's Address _____

Phone # _____

Are there any pets in household? _____

CIRCLE ALL THAT APPLY							
Schedule:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
LIVE-IN	Available 24 h	Available 24 h	Available 24 h	Available 24 h	Available 24 h	Available 24 h	Available 24 h
HOURLY -Please specify shift/s 1. 8am-12pm 2. 1pm-5pm 3. 6pm-10pm 4. 11pm-7am	1. 8am-12pm 2. 1pm-5pm 3. 6pm-10pm 4. 11pm-7am	1. 8am-12pm 2. 1pm-5pm 3. 6pm-10pm 4. 11pm-7am	1. 8am-12pm 2. 1pm-5pm 3. 6pm-10pm 4. 11pm-7am	1. 8am-12pm 2. 1pm-5pm 3. 6pm-10pm 4. 11pm-7am	1. 8am-12pm 2. 1pm-5pm 3. 6pm-10pm 4. 11pm-7am	1. 8am-12pm 2. 1pm-5pm 3. 6pm-10pm 4. 11pm-7am	1. 8am-12pm 2. 1pm-5pm 3. 6pm-10pm 4. 11pm-7am
CHORES:	LAUNDRY	SHOPPING	CLEANING	IRONING	COOKING	HOUSEKEEPING	For how many clients? _____
ASSISTANCE:	KEEPING COMPANY	GOING FOR A WALK	DRESSED & UNDRESSED	PERSONAL HYGIENE	EATING	OTHER: _____	
MENTAL STATUS:	ALERT, DEPRESSED, ANXIETY, CONFUSED, PHOBIAS, ALZHEIMERS, DEMENTIA, COMA,					OTHER: _____	
COMMUNICATION PROBLEMS:	NONE	HEARING	SPEECH	VISION	OTHER: _____		
MOBILITY:	SELF AMBULATES	WALKER	CANE	WHEEL CHAIR	BED BOUND	LEFT PARALYZED RIGHT PARALYZED	CLIENT'S WEIGHT: _____ (LBS)
TOILET:	CONTINENT	INCONTINENT	OTHER: _____				
HYGIENE:	TUB BATH	SHOWER	BED BATH	SPONGE BATH	OTHER: _____		
ORAL HYGIENE:	DENTURES	UPPER	LOWER	BRUSHING TEETH	OTHER: _____		
ILLNESSES & SURGERIES <small>* USE REVERSE SIDE IF NEEDED</small>	PARKINSON, CANCER, DIABETIC, CONGESTIVE HEART FAILURE, KIDNEY FAILURE, EMPHYSEMA, RESPIRATORY CONDITION, HIGH BLOOD PRESSURE ARTHRITIS, ANEURYSM, STROKE, INJURIES : _____ HIP REPLACEMENT, KNEE REPLACEMENT, PACEMAKER, BROKEN BONES, AMPUTEED: _____ OTHER: ATTACH: RN's evaluations, doctors diagnosis, discharge information, medication schedule etc.						
EQUIPMENT:	RECLINING CHAIR, OXYGEN TANK, OXYGEN CONCENTRATOR, CAST, HOYER LIFT, SLIDING BOARD, HOSPITAL BED, SHOWER CHAIR, FEEDING TUBE, COMODE, URINAL, CATHETER, BED PAN, DIAPER					OTHER: _____	
DIET	REGULAR, THICKENED LIQUIDS, BLENDED, DIABETIC, LOW PROTEIN, LOW SALT, LOW CARBOHYDRATES, LACTOSE INTOLERANCE, RAW FOODS, MICROBIOTIC VEGETARIAN, KOSHER, ALLERGIC TO: _____					OTHER: _____	
ASSISTANCE AT NIGHT:	NOT REQUIRED	REQUIRED	HOW MANY TIMES?		MEDICATION	ATTACHED	NOT ATTACHED

HOW DID YOU HEAR ABOUT ICONNEL? _____

IN CASE OF EMERGENCY NOTIFY: NAME, ADDRESS, _____ PHONE # _____

AND OR PRIMARY CARE PHYSICIAN: NAME, ADDRESS, _____ PHONE # _____

AND OR NURSE, OR HOSPICE WHEN APPLICABLE: NAME, ADDRESS, _____ PHONE # _____

AND OR OTHER & RELATIONSHIP: NAME, ADDRESS, _____ PHONE # _____

INFORMATION PREPARED BY: NAME PRINTED: _____	Signature: _____
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Employee: I hereby understand and agree to fulfill all the above duties.

Signature _____ PrintName _____ Date _____

Application Instructions: 3. Signed Advanced Directive Notice

Date _____

Client's Name: _____

Address: _____

This is to certify that ICONNEL has provided me with a copy of the Client's Bill of Rights and advanced Directives and has explained these documents to my understanding.

I have an Advanced Directive:

Yes _____ No _____

Attach a copy of Advanced Directive if applicable.

PRINT PATIENT NAME SIGNATURE OF PATIENT DATE: / /

PRINT NAME OF LEGAL REPRESENTATIVE / POWER-OF-ATTORNEY & RELATIONSHIP TO PATIENT

SIGNATURE OF POWER-OF-ATTORNEY DATE: / /

PRINT NAME OF ICONNEL REPRESENTATIVE

SIGNATURE OF ICONNEL REPRESENTATIVE DATE: / /



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Application Instructions: 5. Signed Service Agreement.

BY THIS AGREEMENT

made and entered into this _____, day of _____, 20____, by and between _____ (hereunder referred to as CLIENT and ICONNEL (hereafter referred to as ICONNEL) for the consideration and promises described herein, the CLIENT and ICONNEL, intending to be legally bound hereby, do hereby mutually agree as follows:

1. ICONNEL agrees to provide **homemaker-home health aide services** on (start date) _____ and end the services on (end date) _____ at the CLIENT'S request.
2. The minimum services agreed will be for four consecutive (4) hours per day, five (5) days per week, for a period of 30 days unless otherwise specified below:
3. The CLIENT agrees to pay ICONNEL a **one-time APPLICATION PROCESSING FEE of \$100** in addition to the service billing rate of:

Day of the Week	Hourly	24 Hour (Live-In) Care
Monday Through Friday Minimum:	\$45 Per Hour	\$450 Per Day
Holidays (New Year's Day, Easter Sunday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day, for the 11-7 shift before and after the holiday, and for the 7-3 and 3-11 shifts. Overtime for excess of forty (40) hours per week or 5 days live-in of service performed by the same employee. Minimum:	\$67.5 Per Hour	\$675 Per Day

4. CLIENT agrees to a WEEKLY billing cycle ending on SUNDAY. Client agrees to the terms of payment: NET UPON RECEIPT. Client understands that unpaid accounts result in immediate termination of services and will be considered in default after thirty (30) days after which interest will be imposed at one and one-half percent per month on any unpaid balances (ANNUAL PERCENTAGE RATE OF 18%). CLIENT agrees to pay the interest and costs of collection, including reasonable attorney's fees, incurred by ICONNEL in collecting the outstanding obligation.
5. The service will be provided for a total of _____ hours / days per day for _____ days per week, and in return the CLIENT agrees to pay ICONNEL a service billing rate of \$_____ per week, and to provide room and board for live-in services. The CLIENT understands that the live-in home health aide is generally entitled to a minimum of eight (8) hours of sleep, four (4) consecutive hours, and two (2) hours total of personal time during any twenty-four (24) hour period. The CLIENT also agrees that the home health aide is entitled to a snack or meal after six (6) hours of in-service activity.
6. A deposit equal to two (2) weeks of the weekly service billing is required upon signing this agreement. This deposit will be used towards the last two weeks of the service, OR when the CLIENT defaults on a timely payment of services invoiced. Any remaining deposits will be returned to the CLIENT.
7. The CLIENT is responsible for signing the weekly time sheets serviced to the CLIENT by ICONNEL's employee(s). In the event that the CLIENT omits signing the timesheet, this agreement will serve as an automatic default guideline for billing.
8. When live-in services are provided, the CLIENT agrees to provide a separate room, separate bed, appropriate and reasonable amount of linens, laundry detergents, cleaning supplies, and food.
9. The CLIENT agrees to make all payments to the name of ICONNEL only, and is strictly prohibited from making any form of payment directly to ICONNEL's employees, including tips and gifts.
10. The CLIENT agrees that all valuables, including money, jewelry, and personal financial records are to be kept in a secure and safe place as recommended by the State of New Jersey Division of Consumer Affairs and the New Jersey Board of Nursing.
11. The CLIENT agrees that the scope of services rendered by ICONNEL pertain only to the CLIENT and not to any other members of the household, including animals and pets.
12. The CLIENT may not hire the assigned ICONNEL employee directly or privately. Failure to comply with this policy will result in a material breach of this agreement. In the event that a direct hire arrangement is recognized by ICONNEL, the client agrees to pay ICONNEL a fee of twelve thousand dollars(\$12,000).
13. It is important that the CLIENT cooperates with ICONNEL to ensure that a cost effective service is provided. In the event that the CLIENT is found to be involved in the manipulation or cooperation with our employee to increase the management costs of ICONNEL, such as producing an



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Application Instructions: 6. Automatic Payments Agreement.

We require our services to be prepaid two (2) weeks in advance. The 2 weeks' deposit will be used towards the last two weeks of service and will be credited to your account. (**For example** live-in help, the security deposit based on \$450/daily rate x 7 days x 2 weeks = \$6,300.)

Authorization Agreement for Automatic Credit Card Payments

I hereby authorize ICONNEL to deduct any amounts owed by me by initiating credit card debits from my credit card information below. Further, I authorize my Credit Card company to accept any credit entries initiated by ICONNEL as well. In the event that ICONNEL debits or credits funds erroneously from my account, I authorize ICONNEL to make adjustments for any such amount.

Credit Card Number _____

Expiration ____/____

SIC Code on back of card _____

Card Type (circle one) Master Card, Visa, Discover

Bank issuing credit card _____

Billing Address for credit card

This authorization is to remain in full force and effect until ICONNEL and/or Bank has received written notice from me of its termination in such time and in such manner as to afford ICONNEL and/or Bank a reasonable opportunity to act on it.

Authorization Signature of Card Holder

Signature Date



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NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2004

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

For purposes of this document “you” is defined as the ICONNEL client. If you have any questions about this notice, please contact ICONNEL at 1-800-915-4266.

WHO WILL FOLLOW THIS NOTICE.

This notice describes ICONNEL practices and that of:

- Any health care professional authorized to enter information into your medical record.
- All departments or units of and/or sites operated by ICONNEL
- All employees, staff and other ICONNEL personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to maintaining the confidentiality of medical information about you. We create a record of the care and services you receive at ICONNEL. We need this record to treat you and to comply with certain legal requirements. This notice applies to all of the records of your care generated by ICONNEL, whether made by your personal doctor, counselor or by other personnel engaged by ICONNEL to provide services to you.

This notice advises you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

make sure that medical information that identifies you is kept private;
give you this notice of our legal duties and privacy practices with respect to medical information about you; and
follow the terms described in this notice.



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HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and provide examples. Not every use or disclosure in a category will necessarily be listed below. However, all of the ways which we are permitted to use and disclose information will fall within one of the categories.

Treatment - We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, therapists, counselors, social workers or other ICONNEL personnel who are involved in your medical care and treatment. We also may disclose medical information about you to people outside of ICONNEL who may be involved in your medical care after you are discharged from ICONNEL, such as family members, clergy or others we may rely upon or ask to assist us in caring for you.

Treatment Alternatives - We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. For example, we may use your information to determine whether you qualify for a nutritional counseling program.

Health-Related Benefits and Services - We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Health Care Operations - We may use and disclose medical information about you for ICONNEL operations. These uses and disclosures are necessary to run the ICONNEL organization and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many ICONNEL clients to decide what additional services ICONNEL should offer, what services are not needed, and whether certain new approaches to care and treatments are effective. We may also disclose information to doctors, nurses, therapists, counselors, social workers and other ICONNEL personnel for review and learning purposes. We may also combine the medical information we have with medical information from other organizations similar to ICONNEL to compare how we are doing and see where we can make improvements in the care and services that we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Individuals Involved in Your Care or Payment for Your Care - We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care, for example parent, child or other relative or individual who has power of attorney.

As Required By Law - We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety - We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Organ and Tissue Donation -If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Public Health Risks - We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities - We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes -If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if required by law or if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement - We may release medical information if requested by a law-enforcement official acting pursuant to valid legal authority.

Coroners, Medical Examiners and Funeral Directors - We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

With Your Written Permission - We may disclose medical information about you pursuant to your written consent or authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy - You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to ICONNEL., 246 West 38th Street Floor #10, NY, NY 10018. If you request a copy of the information, we may charge a fee as permitted by state law for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by ICONNEL will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend -If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the office.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at all applicable ICONNEL locations. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with ICONNEL or with the Secretary of the Department of Health and Human Services. To file a complaint with ICONNEL, contact ICONNEL 246 West 38th Street Floor #10, NY, NY 10018. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



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More Info:

If you would need more information about advance directives, the organizations listed below will be pleased to assist you:

Citizens Committee

On Bio Medical Ethics -

(973) 857-5552 - 13

Rockland Ter,

Verona, NJ 07044

ICONNEL.
246 West 38th St. 10th Floor
NY, NY 10018

ADVANCE DIRECTIVES GUIDE FOR HOME CARE PATIENTS AND FAMILIES

ICONNEL.
246 West 38th St. 10th Floor
NY, NY 10018



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All competent adults of 18 years and over admitted to our agency for services must be advised under Federal and State Law that they have right to execute an advance /living will if they so desire.

An advance directive is defined as oral or written direction you prepare in advance to say what kind of medical care you want in the event you become unable to make decisions for yourself.

This means that you can choose medical treatment ranging from extensive life support measures to no treatment at all.

There are 3 different ways to have an advance directive:

1. Proxy Directive
2. Instruction Directive
3. Combined Directive

Proxy Directive

Allows you to designate the person you trust who will make medical decisions on your behalf if you are unable to do so.

An Instruction Directive

Is a set of written directions that spell out in advance what medical treatment you accept or refuse and the circumstances under which you want your wishes implemented.

A Combined Directive

Is a combination of the proxy directive and instructive directive.

Our agency/home care company recommends that if you choose to execute your right to have an advance directive/living will, that you share this document with your physician, family members, and health care professionals who are caring for you.

We will keep a copy of your advance directive on file with your medical record so that all appropriate agency personnel are aware of your wishes.

It is not requirement of this agency/company that you have an advance directive to receive service, and we will not discriminate against patients who choose not to execute such a document.

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Visit Our Customer Friendly Web Site
www.ICONNEL.com

to get familiar with our personnel.



We also offer the following Services:

- **Shopping Service**
- **Housekeeping & Maintenance**
- **Bath Service**
- **Bill Payment Service**
- **Home Web-Aide Monitoring Service**
- **Errand Service**
- **Entertainment & Socialization**
- **Referral Service for services not included in our list.**

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ICONNEL

Fully Insured, Bonded & Licensed

Health Care Service Firm

offering

NJ State Certified

Homemaker-Home Health Aides

Trained and Supervised by RNs

Available

Live-in

And

Hourly

All personnel staffed exclusively by

[White Glove Intercare, Inc.](http://www.whitegloveintercare.com)

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E-mail: info@ICONNEL.com

About NJ State Regulations:

We comply with all the rules, regulations & licensing requirements of the Division of Consumer Affairs of the State of New Jersey, New Jersey Board of Nursing and NJ Dept of Health and Senior Services.

We would like to express our special thanks to the NJ Division of Consumer Affairs and the NJ Board of Nursing for the patronage over safety and mutual benefit of all the parties involved in Senior Services in the State of NJ. We are grateful to NJ Division of Consumer Affairs & NJ Board of Nursing for their performance of criminal background checks of all Certified Homemakers Home-Health Aides licensed in the State of New Jersey. Here are their helpful hints from "A Consumer's Guide to Homemaker-Home Health Aides":

- Select a home care provider with the same care and attention you would apply to any important decision.
- Contact Medicare, Medicaid or your insurance carrier to determine which home care services are eligible for reimbursement.
- Obtain and read the literature describing the home health care agency's services, reimbursement procedures and patient rights.
- Select an agency that can provide the coverage you will need. The number of service hours will be determined by the Registered Professional Nurse and your insurance company. Be specific about the number of hours (either daily or weekly) that you will need a CHHA. Clarify, in advance, whether the same CHHA will be available.
- Be sure to contact the home care services agency with any concerns you may have related to your care. Contact the NJ BON to file a complaint about nurse or CHHA.
- Keep thorough health records and maintain them in a place where others can easily locate them.
- Always keep valuables, money, jewelry and personal financial records in a safe place.

About us:

Our scope of services, policies & procedures, employees' credentials, education and training programs, insurance and licensing comply with the requirements of NJ Board of Nursing. (NJ BON).

Per NJ BON requirement a Registered Professional Nurse (RN) develops and supervises the plan of care implemented by the Certified Homemaker-Home Health Aide (CHHA).

General functions provided to a patient by Certified Homemaker-Home Health Aide (CHHA) and authorized by NJ Board of Nursing:

State Certified Homemaker Home Health Aide Service Guide:

1. Provides a safe environment for the patient and family.
2. Gives full or partial bath - in bed, tub or shower. (Tub bath can be given only with permission from Nursing Supervisor.)
3. Assists with patient's personal grooming, including care of hair, teeth and mouth, foot care, dressing, shaving, and nail care (other than cutting of nails).
4. Assists patient in walking and in moving from bed to chair or wheelchair.
5. Prepares and serves simple meals according to patient's specific diet needs; assists patient with eating.
6. Performs household tasks essential to the patient's health, such as:
 - Keeps patient's room neat and clean including dusting and vacuuming;
 - Makes and changes the bed - occupied or unoccupied;
 - Tidies up bathroom and kitchen after use, including dish washing after meals;
 - Does the patient's personal laundry and bed linen;
 - Does food marketing needed for patient.
7. Assists with oral medication ordered by the doctor that can be self-administered.
8. Follows orders and keeps simple records as instructed by

the Nursing Supervisor, who consults with the physician and family.

9. Accompanies the patient to the physician's office or medical facility when necessary, but is not allowed to drive any vehicle.
10. Provides socialization.

About our personnel:

All our Certified Homemakers-Home Health Aides meet the following requirements:

1. Completion of Homemaker Home-Health Aide course approved by NJ BON.
2. Successful completion of a competency evaluation by the home care agency.
3. Hold a current and valid certification by NJ BON as a Homemaker Home-Health Aide. The certificate will have a State of NJ Seal and the date of expiration; certificates expire every 2 years. Should you have any questions concerning a CHHA's certification, you should call the NJ BON at 973-504-6507
4. Completion of the Federal and State criminal history background checks.
5. Employment by home care service agency.
6. Supervision by a licensed Registered Professional Nurse.
7. Medical background check.
8. In-service training.



**All personnel staffed by
White Glove Intercare, Inc.**

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