STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
PO BOX 726
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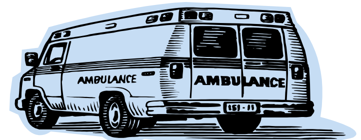
Assistant Commissioner

TEL. (609) 631-2200

Acknowledgement of Receipt of Information Regarding *"Danielle's Law"*

I have received the following information pertaining to Danielle's Law:



In accordance with Danielle's Law, 911 is to be called in life threatening emergencies. As defined in the law, "Life threatening emergency means a situation in which a prudent person *could* reasonably believe that immediate intervention is necessary to protect the life of a person receiving services, or to protect the lives of other persons at the facility or agency from an immediate threat or actual occurrence of a potentially fatal injury, impairment to bodily functions or dysfunction of a bodily organ or part."

Failure to call 911 in a life threatening emergency includes monetary fines: $5,000 for the first offense, $10,000 for the second offense, and $25,000 for the third and each subsequent offense. Additionally, a health care professional, licensed or alternately authorized to provide services, may be subject to revocation of that professional license or other authorization to practice as a health care professional.

I have received training on Danielle's Law including a Power Point Presentation on Danielle's Law, a copy of Danielle's Biography, a Fact Sheet on Life Threatening Emergencies, and a copy of Chapter 191, the actual Law.

I understand that it is my responsibility to call 911 if a person served by the Division of Developmental Disabilities is experiencing a life threatening emergency, as defined in Danielle's Law." I understand it is the responsibility of the emergency medical professionals to assess the severity of the emergency. My responsibility is to make the call to 911, provide information regarding the condition of the person, and direct emergency workers to the scene of the emergency. It is also my responsibility to provide immediate care until the emergency medical professionals arrive and take over.

______________________________ ______________
Signature **Date**

______________________________ ______________
Print Name **Title**

KOMNINO'S LAW ACKNOWLEDGEMENT

Acknowledgement of Receipt of Information Regarding "Komnino's Law"

I have received the following information pertaining to Komnino's Law:

Komnino's Law (P.L. 2017 Chapter 238), provides protections for individuals with developmental disabilities through accountability and transparency.

Protections have been made as follows:

1. **Random and frequent DHS Site visits** – Unannounced visits and evaluations from DHS designated employees will take place multiple times per year. Staff must allow properly identified individuals into the program and provide requested information as needed for the visit/evaluation.

2. **Reporting Injury Timeline** – Every staff member must report to their manager, any injury to service recipients including those as a result of abuse, neglect or exploitation, as soon as it is safe to do so and immediately if the situation allows. Management will relay needed information to DDD, guardians, and HIPAA approved individuals within the 2-hour timeframe for reporting.

3. **Drug Testing -** Any person applying for employment as a direct care staff member at a program, facility, or living arrangement licensed or funded by the department (DHS), shall consent to and undergo drug testing for controlled dangerous substances as a condition of such employment.
    a. Testing positive for unlawful use of any dangerous controlled substance or refusing to submit to drug testing will prevent consideration of employment.
    b. Employees will be selected randomly throughout the year for drug testing. Testing positive for unlawful use of any dangerous controlled substance or refusing to submit to drug testing will result in employment termination.

4. **Meetings with and sharing Contact information** - In order to provide an opportunity for parents and guardians to share experiences about the individuals in accordance with Komnino's Law, the agency will request contact information from each parent or guardian of an individual with a developmental disability. The agency will advise the parent or guardian that, if the parent or guardian agrees, the agency will exchange contact information with other parents and guardians of individuals with developmental disabilities.

I acknowledge that I have received training on Komnino's Law, how it affects my workplace and what my responsibilities are in these situations.

____
Staff Name Printed

____ ____________________
Signature Date

HIPAA EMPLOYEE TRAINING ACKNOWLEDGEMENT FORM

STATEMENT

I acknowledge that I have received and thoroughly reviewed Alay Home Care's HIPAA Education Handouts and attended the HIPAA Training session on the date signed below. This session included training on the federal and state laws and regulations regarding the HIPAA privacy and security rules requiring the use of confidentiality as well as integrity accessibility safeguards for patient protected health information (PHI).

I agree to comply strictly with the principles set forth in the Alay Home Care's training on HIPAA and the Organization's Privacy & Security Policies and Procedures, which include but are not limited to:

- Minimum necessary;
- Maintaining confidentiality of PHI;
- Patient privacy rights under HIPAA;
- Password management;
- Log-in procedures and requirements; and
- Identifying and reporting security incidents.

I received training on and understand the policies and procedures specific to my job functions.

I agree to follow the policies and procedures and otherwise maintain the confidentiality and integrity of PHI.

I understand that I will be subject to disciplinary action up to and including termination if I violate the principles set forth in the HIPAA training session.

I further understand that the HIPAA Privacy & Security Policies and Procedures are not a contract of employment.

____________________	____________________	____________
(Signature)	(Title)	(Date)

ANNUAL PLEDGE OF CONFIDENTIALITY

I,____, ______________________

(PRINT NAME AND TITLE)

Fully understand that all patient information, clinical and administrative records are confidential material to be treated as confidential to respect and protect the rights of patients, adhere, to Federal Law (HIPAA) regarding the protection of patient health information and maintain the credibility of the Company.

I have also been oriented to the Company's policy on confidentially HIV Related Information.

I am aware that:

Only those personnel who need information to provide health care to a patient have the right to read records, in so far as his/her job requires it. This information must be kept confidential and discussed in a private setting only by those involved in his/her care.

No person to whom confidential HIV Related Information has been disclose shall disclose the information to another person except as authorized by law.

During my initial orientation, I was given and hold a copy of the Orientation Manuel/Employee Handbook, which contains information on confidentiality, HIV confidentiality and includes the agency's Ethics Statement.

It is my responsibility to protect the right of confidentiality of all patients.

As an employee of Alay Home Care, I have read the entire agency's policies and procedures as they relate to confidentiality.

I understand any violation of this policy can result in termination.

______________________________ ______________________________ ____________________

(Signature) (Title) (Date)

RE-ORIENTATION ACKNOWLEDGEMENT FORM

VERIFICATION OF:

1. Alay re-orientation
2. Company Policy
3. HIPAA Training
4. Danielle's Law
5. Komnino's Law

IMPORTANT NOTICE

I hereby authorize each of my former employers and/or agencies given as reference, to respond truthfully to all inquiries made by Alay Home Care and give all other pertinent information that may be sought by Alay Home Care.

In consideration of Alay Home Care placing me, I agree not to directly or indirectly accept or seek employment from any client of Alay Home Care that I have been assigned to, for a period of not less than three (3) months from the last date I was assigned to the client. This restriction shall remain in force up to three (3) months after the last date I was placed by Alay Home Care. If I violate this agreement, I agree to pay upon demand, to Alay Home Care, the sum of $750.00 as liquidated damages.

The following "Employment at Will Statement"ensures that neither the employee nor the agency is bound by the contract for lifetime employment. As an employee you have the right to terminate your employment with Alay Home Care at any time and for any reason. Alay Home Care reserves that same right. The "Employment at Will Statement"is not unique to Alay Home Care, and does not represent a change from past policies and practices.

EMPLOYMENT AT WILL STATEMENT

I understand that my employment may be terminated with or without cause and with or without notice any time at the option of either the agency or myself. I further understand that no management representative has any authority to enter into any agreement of employment for any specific period of time or to make any agreement contrary to the foregoing.

I hereby authorize Alay Home Care to submit a request to the Attorney General of the United States to conduct a search of the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other identification information submitted by me. I further authorize the exchange of such information between the Attorney General of the United States, the State of New Jersey Department of Human Services and Alay Home Care. This information may be used only by Alay Home Care and only for the purpose of determining my suitability for employment in a position involved in direct patient care.

I hereby release Alay Home Care from any and all claims I may have for its decision not to employ me based upon the Criminal History Record Check results it obtains. I understand that I will not be eligible for unemployment insurance benefits if I am terminated for cause, including termination based upon conviction for a criminal act constituting a felony or any other regulatory disqualifying act.

I affirm and acknowledge that I was provided with an employee re-orientation.

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Employee Name (Print)

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Employee Signature

____

Date