ΩMEGA
Home Health Care Services LLC

2700 East Dublin Granville Rd #195
Columbus, OH 43231
Phone 614-431-6444
Fax: 614-453-8188

Pre-Hire Checklist

☐	☐ DL/State ID ☐ Green Card/Emp Authorization Card ☐ Social Security ☐ Passport/Citizenship
☐	Proof of Auto Insurance ☐ Non-Driver
☐	Have you been a resident of OH for the last five years? ◯ Yes ◯ No If Yes: ☐ Proof of 5 years' residence of OH ☐ BCI If No: ☐ Fingerprint Results
☐	The FRRF/ARCS Form
☐	TB Test Results; PPD or X-ray
☐	CPR Training Certificate
☐	Have you worked as an HHA for more than one year? ◯ Yes ◯ No If Yes: ☐ provide document to prove one or more year of related work If No: ☐ HHA Certificate ☐ HHA Training Course Zist (NATCEP)
☐	Home Health Aide Competency Test
☐	Initial Competency Checklist

Employee Name:_____ **Date**: _____

Reviewed By: _____ **Hire Date**: _____

HOME HEALTH AIDE COMPETENCY TEST

Answer Sheet

Name _____ SS# _____ Date _____

Mark your answer on this test answer sheet by circling the letter that corresponds with your answer.

1. A B C D	21. A B C D	41. A B C D
2. A B C D	22. A B C D	42. A B C D
3. A B C D	23. A B C D	43. A B C D
4. A B C D	24. A B C D	44. A B C D
5. A B C D	25. A B C D	45. A B C D
6. A B C D	26. A B C D	46. A B C D
7. A B C D	27. A B C D	47. A B C D
8. A B C D	28. A B C D	48. A B C D
9. A B C D	29. A B C D	49. A B C D
10. A B C D	30. A B C D	50. A B C D
11. A B C D	31. A B C D	51. A B C D
12. A B C D	32. A B C D	52. A B C D
13. A B C D	33. A B C D	53. A B C D
14. A B C D	34. A B C D	54. A B C D
15. A B C D	35. A B C D	55. A B C D
16. A B C D	36. A B C D	56. A B C D
17. A B C D	37. A B C D	57. A B C D
18. A B C D	38. A B C D	58. A B C D
19. A B C D	39. A B C D	59. A B C D
20. A B C D	40. A B C D	60. A B C D

_____ _____

Signature of RN Administering Test Title/Position

INITIAL COMPETENCY CHECKLIST

Home Health Aide

Name _____ Title _____

Skills	Competent		Comments	Initial & Date
	Yes	No		
T, P, R, BP: reading & recording	☐	☐		
Bed Bath	☐	☐		
Sponge, tub, or shower bath	☐	☐		
Shampoo; sink, tub or bed	☐	☐		
Oral hygiene	☐	☐		
Toileting & Elimination	☐	☐		
Normal range of motion	☐	☐		
Positioning	☐	☐		
Safe transfer techniques	☐	☐		
Ambulation	☐	☐		
Fluid intake	☐	☐		
Adequate nutrition	☐	☐		
Communication skills	☐	☐		
Infection control: Standard precautions	☐	☐		
Observing & reporting pt status & care furnished	☐	☐		
Documenting pt status & care furnished	☐	☐		
Maintenance of clean, safe & healthy environment	☐	☐		
Elements of body function & changes to report to supervisor	☐	☐		
Recognition of emergencies	☐	☐		
Knowledge of emergency procedures	☐	☐		
Physical, emotional & developmental needs & ways to work with patients	☐	☐		
Respect for patient	☐	☐		
Respect for patient privacy	☐	☐		
Respect for patient property	☐	☐		

Date of Completion _____ Observed in home with patient ☐ Yes
Home Health Aide Competent to Provide Care: ☐ Yes ☐ No

_____ _____

Employee Signature/Title *Observer Signature/Title*

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Employment Termination Agreement

I, _____ am clearly informed by the agency that my employment will stay active if the job duties are performed satisfactorily as assigned based on consumers' care plan. I also understand that if for some reason consumers move out of agency or relocate, my employment here at Omega Home Health Care services, LLC will be automatically terminated.

_____ _____
Employee Signature Date

_____ _____
Human Resource Date