CORPORATE
PAYROLL SERVICES
2 Neshaminy Interplex Suite 104
Trevose, PA 19053
(215) 244-2580
www.corpay.com

DATE: ___/___/___ CUSTID: _____

Company Name: _____

Employee ID/Name: _____

Employee Bank Routing Number: _____

Employee Bank Account Number: _____

This letter confirms the above listed Company and Employee accept full liability for Corporate Payroll Services providing direct deposit service to the above listed Employee bank routing and account number. This bank account only allows money to be deposited into it, not drafted from it. Therefore, it is considered a non-transaction bank account. If a payroll error occurs that results in the Employee being overpaid, regardless of who is at fault, the Company understands Corporate Payroll Services will be unable to retrieve any funds from this bank account. As a result, the Company cannot be reimbursed by Corporate Payroll Services for any money erroneously paid to the Employee.

Agreed and understood,

_____ _____ _____

Authorized Payroll Contact Employee Corporate Payroll Services

Corporate Payroll Services

Authorization Agreement For Direct Deposit Employees

For direct deposit employees, this Authorization Agreement along with voided check(s) or deposit ticket(s) must be received a minimum of 5 banking days before the first direct deposit pay date. This Authorization Agreement may be initially faxed along with a copy of voided check(s) or deposit ticket(s) to (215) 244-2581. Originals must be received by us within 5 business days.

Employee Name _____ Employee ID #_____

Company Name _____ Cust. ID #_____

Corporate Payroll Services cannot set up direct deposits for "credit only" accounts. These accounts do not allow debit entries, which are necessary for voiding and reissuing checks.

Corporate Payroll Services does not offer direct deposit of funds to either a foreign bank or a U.S. Financial institution where the entire amount will be forwarded to a bank account in another country. If either situation applies to you, do not complete this form.

If you only have one account, simply write 100 next to the % sign in the first row. You may choose up to 4 accounts into which your net pay is deposited. Please enter either a dollar amount or a percentage for all accounts. If you choose the Dollar Method, all remaining amounts will be directed to the first account listed below. If using the Percentage method, the total of the percentages must equal 100%.

$ All Remaining OR _____% * Bank Name _____ Checking____ Savings____

Routing_____ Acct#_____

$_____ OR _____% * Bank Name_____ Checking____ Savings____

Routing_____ Acct#_____

$_____ OR _____% * Bank Name_____ Checking____ Savings____

Routing_____ Acct#_____

$_____ OR _____% * Bank Name_____ Checking____ Savings____

Routing_____ Acct#_____

*Total for ALL % amounts must = 100

I hereby authorize Corporate Payroll Services, its agents and the bank named above to initiate credit and any necessary adjusting debit entries to my account(s) indicated above. This Authority is to remain in effect until Corporate Payroll Services and the bank have received written notice from me of its termination in such time and manner as to afford Corporate Payroll Services and the bank a reasonable opportunity to act on it.

Signature _____ Date ____/____/____

*Please email my direct deposit stub to : _____

Staple copy of voided check(s) to this form when sending originals

For office use only: Entered by _____ Date_____ Email entered? Y N Notes: _____

Verified by _____ Date _____ Email verified? Y N Notes: _____

CORPORATE PAYROLL SERVICES

Non-Transaction Bank Account Authorization

CUSTID: _____ _____ _____ _____ _____ _____ DATE: _____/_____/

Company Name:

Employee ID: _____ Name:

Financial Institution Name and Account Information:

Name:

Routing Number:

Account Number:

Account Type:	☐ Checking	☐ Savings	☐ FSA
☐ Misc. Pay Card	☐ IRA\401K	☐ SOLE/Comdata Card	☐ HSA

The Company and Employee listed above and Corporate Payroll Services hereby agree as follows: The above listed bank account only allows money to be deposited into it, not drafted from it. In consideration of Corporate Payroll Services providing direct deposits to the Company and the Employee, the Company understands that if an error results in the Employee being overpaid, Corporate Payroll Services may be unable to retrieve any funds from this account. In such event, the Employee agrees to immediately reimburse the Company for any overpayment. The Company agrees that it will not be reimbursed by Corporate Payroll Services for any money erroneously paid to the Employee regardless of the amount or who is at fault for any overpayment. In the event, Corporate Payroll Services has paid the Employee money for which it has not been reimbursed, the Company and/or Employee will immediately reimburse Corporate Payroll Services for all overpayment amounts and will be jointly and severally liable for all amounts due Corporate Payroll Services.

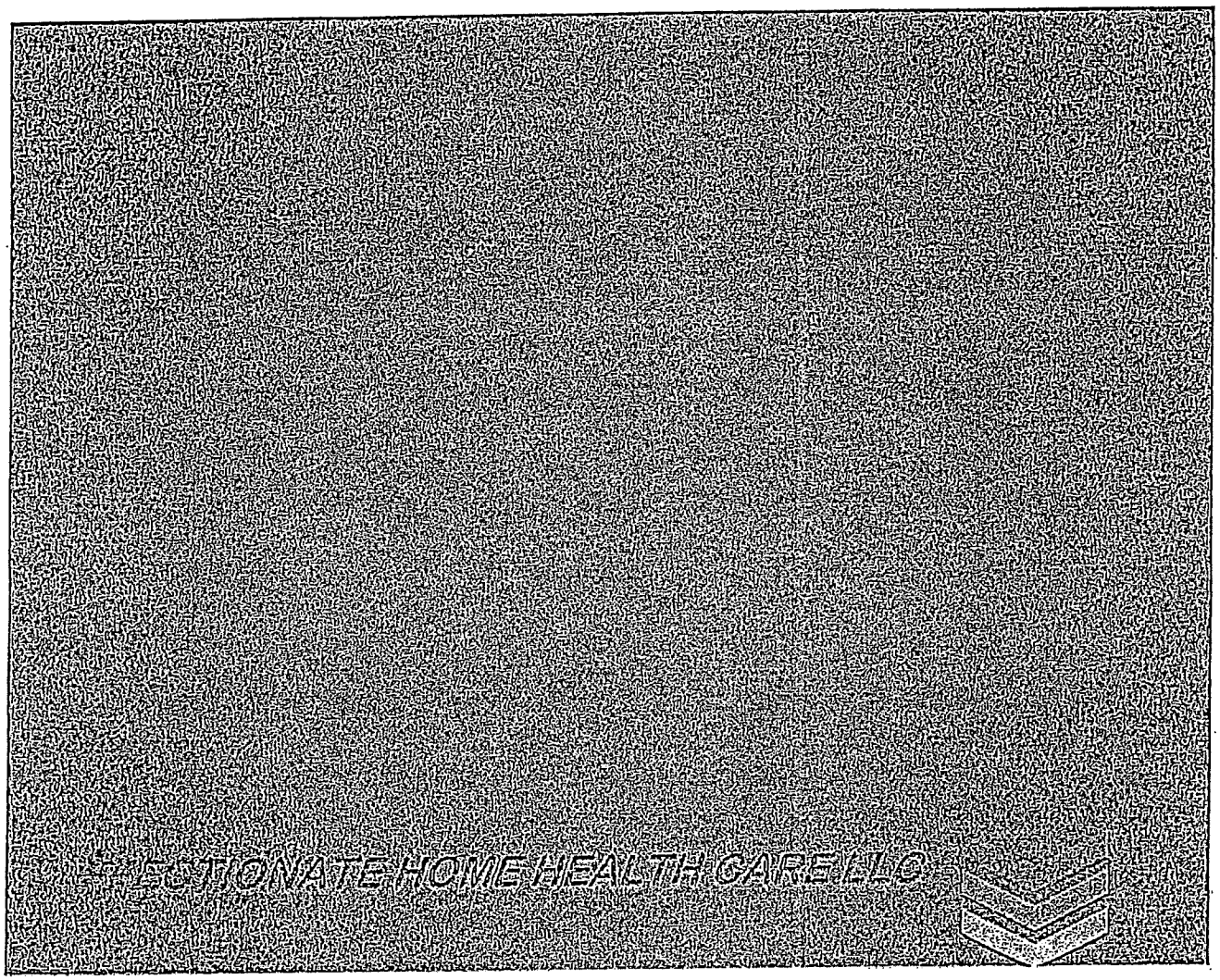
Agreed and understood,

Authorized Company Signature	Employee Signature	Corporate Payroll Services

For office use only: ☐ Deduction Added to EE ☐ Pay Type Added to EE ☐ W2 Code updated ☐ DD Prenoted ☐ Billing Updated

Entered by _____ Date ___/___/_____ Verified by _____ Date ___/___/_____

	Atlanta	Charlotte	Chicago	Philadelphia	Washington DC
Phone:	770.446.7289	704.827.0901	630.368.1975	215.244.2580	301.610.9410
Fax:	770.263.6433	704.827.8555	630.368.1976	215.244.2581	301.610.9411



HIPAA

Employee Confidentiality Privacy Information and Agreement

1. *Privacy for Employees when on assignment*

   a. Agreement

2. *Notice of Advance Care Staffing Privacy Practices*

   a. Acknowledgement and Consent

SUMMARY OF HIPAA PRIVACY RULES FOR TEMPORARY PERSONNEL

The Department of Health and Human Services has adopted privacy regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These "Privacy Rules" require most doctors, hospitals and health insurers ("Covered Entities") to develop procedures to limit the use and disclosure of patients' protected health information ("PHI") as well as notify patients of their rights with respect to such information.

In order to comply with the Privacy Rules, each Covered Entity must develop and implement its own privacy policy and procedures for the protection of PHI by April 14, 2003. However in many ways, these policies will simply reflect the "best practices" for patient privacy and confidentiality with which all health care workers should already be familiar.

Privacy of Patient Information

Although temporary personnel are likely to encounter some variations among privacy policies at different Covered Entities, all the policies should permit them (with a few exceptions) to:

- Disclose PHI to the patient himself (or to a child's parent or guardian).
  - PHI may also be disclosed to a person involved in the patient's care, such as an elderly patient's adult child or friend who is acting as interpreter, as long as the patient doesn't object.
  - There are few exceptions, such as psychotherapy notes in some states.
- Disclose PHI in accordance with a written patient authorization.
- Use or disclose PHI for purposes of treatment, payment or health care operations.
  - Treatment purposes: There are no restrictions on disclosures of PHI for purposes of treating a patient. Medical staff may freely discuss a patient's treatment among themselves.
  - Other Purposes: However, disclosures of PHI for purposes of obtaining payment or for administering health care operations should be limited to the "minimum necessary" to accomplish the purpose. For example, although a hospital's billing office may inform a collection agency that "Patient X owes $Y to Doctor Z", it may not disclose the nature of treatment Patient X received.
- Disclose "general directory information" about the patient.
  - A hospital may provide general information about a patient's status (excluding specific medical information) to telephone callers, or provide a list of Methodist patient's to a visiting Methodist minister, as long as the patient hasn't objected.
- Disclose PHI as required by law, or regarding potential victims of abuse, neglect or domestic violence, or to avoid a serious threat to health or safety.
  - For example, a hospital may respond to a police inquiry by disclosing that is treated a patient for a gunshot wound, and a doctor or nurse may report an abused child to the proper authorities.

If you are asked to make any disclosures which violate these guidelines, or which do not seem to you like professional "best practices", you should contact Advanced Care Staffing.

(However, you should be aware that reasonably unavoidable disclosures which are "incidental" to permitted uses of PHI do not violate the Privacy Rules. For example, a hospital does not violate the Privacy Rules if a visitor improperly removes a covered or inward-facing patient chart from its holder and reads it, and a pharmacist may discreetly discuss a prescription with a customer at the pharmacy counter, even though other customers might overhear).

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how many obtain access to this information. Please review it carefully. At Affectionate Home Health Care, we respect the confidentiality of your medical information and will protect information in a responsible manner. We have a privacy program in place that meets the requirements of HIPAA, the government legislation that sets standards for the privacy of medical information. This notice will be effective for all medical information that we maintain, including medical information we created or received.

DEFINITION OF MEDICAL INFORMATION

When Advanced Care Staffing refers to medical information, we mean protect health information (PHI). PHI is information that is individually identifiable health information including demographic information collected.

USES AND DISCLOSURES OF PHI

Health Care Operations- Your medical information may be used and disclosed in connection with our health care operational including:

- Case management and care coordination.
- Quality assessment and improvement activities and protocol assessment.
- Reviewing the competence or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification activities, and credentialing activities.
- Conducting legal services, compliance programs, fraud and abuse detection
- Business planning and development.

Additional disclosures-PHI may be disclosed;

- To another entity that has relationship with the organization for their health care operations relating to quality improvement and assessment activities, reviewing competence or qualifications of health care professionals.
- To other entities that assist us in conducting our health care operations.

We will not disclose your medical information to those persons or entities unless they agree to keep it protected.

Assigned Employee Confidentiality and Privacy Agreement

Date: _____

As a condition of my assignment by Affectionate Home Health Care, LLC with any assigned Care, I hereby acknowledge and agree as follows:

I will not use, disclose, or in any way reveal or disseminate to unauthorized parties any information I gain through contact with materials or documents that are made available through my assignment at Client or that I learn about during such assignment.

I will not disclose or in any way reveal or disseminate any information pertaining to Client or its operating methods and procedures that comes to my attention as a result of this assignment.

Under no circumstances shall *I* remove copies or documents from the premises of Client.

I have read the attached "Summary of HIPAA Privacy Rules for Personnel" and understand it. During my assignment with at Client, I will abide by the principles described in this attached summary as well as any privacy policy provided to me by the Client. In particular, I will not use, disclose or in any way reveal or disseminate any protected health information that I learn in connection with any assignment, except in accordance with such principles and privacy policy.

I understand that I shall be responsible for any direct or consequential damages resulting from any violation of this Agreement. This obligation of this Agreement shall remain in effect even after my employment by Affectionate Home Health Care has ended.

Assigned Employee	Witness
_____	_____
Printed Name	Printed Name
_____	_____
Signature	Signature
_____	_____
Date	Date

For the Public Benefit- as authorized by law for the following purposes:

- As required by law
- For public health activities, including disease and vital statistic reporting, FDA oversight, and for work related illness or injury
- To health oversight agencies
- In response to court and administrative orders
- To avert a serious threat to health and human safety

Your written authorization is required for all other uses and disclosures of your PHI. You may revoke your authorization at any time. However, your revocation will not affect any use or disclosure you permitted to your revocation.

YOUR RIGHTS

Access to your information — You have the right to inspect or obtain a copy of the medical information about you that is contained in a "designated record set". The organization may ask you to submit your request in writing.

Accounting of disclosures – You have the right to receive a list of instances in which we or our associates disclosed your PHI for purposes other than health care operations or those authorized by you.

Confidential Communication – You have the right to request that we communicate with you about your PHI by a different means or at a different location. You make this request in writing,

Amending your PHI – You have the right to request that we amend your PHI contained in the "designated record set" if it is not correct or complete. We may require that this request be in writing.

Complaints – You have the right to file a complaint if you believe your privacy rights have been violated. You may file this complaint with Affectionate Home Health Care and/or the Secretary of the Department of Health and Human Services. All complaints to Affectionate Home Health Care must be made in writing. We support your right to protect your PHI.

HIPAA PRIVACY NOTICE

ACKNOWLEDGEMENT AND CONSENT

I acknowledge that I have been provided with a notice of privacy practices and have been advised of how health information about me may be used and disclosed by Affectionate Home Health Care and how may I obtain access to and control of this information.

_____ _____

Signature/Title Date

Affectionate Home Health Care
14S Lansdowne Ave
Lansdowne Pa, 19050
484-461-4369
Affectionatehhc@yahoo.com

NON DISCRIMINATION

Attention: Employees of Affectionate Home Health Care:

In accordance with title VI of the Civil Rights Act of 1964 and its implementing regulation, the agency will not, directly or through contractual arrangements discriminate on the basis of race, color, or national origin in its admissions or its provision of services and benefits, including assignments of transfers or referrals to or from the agency. Staff privileges (if appropriate) are granted without regard to race, color, or national origin.
In accordance with Section 504 of the Rehabilitation Act of 1973 and its implementing regulation, the agency will not directly or through contractual arrangements, discriminate on the basis of disability in admission, access, treatment or employment. The agency Director of Nursing will serve as the section 504 Coordinator.
In accordance with the Age Discrimination Act 1975 and its implementing regulation, the agency will not directly or through contractual or other arrangements, discriminate on the basis of age in the provision of services, unless age is a factor necessary to normal operations or the achievement of any statutory objective.
In accordance with the "Pennsylvania Human Relations Act", the
agency will not directly or through contractual or other arrangements, discriminate because of race, color, religious creed, ancestry, age, or national origin.. If you have any questions or concerns regarding our policy, please do not hesitate to contact Affectionate Home Health Care.

Thank you, in advance, for your understanding in this matter.

Sincerely,

Affectionate Home Health Care *Your signature indicates that you fully understand and agree to follow the rules of the above statement.*

Print _____

Sign _____

Date_____