HEROES. WORK. HERE.

# Employee HANDBOOK



NOT EVERY HERO WEARS A CAPE

Broadway HOME CARE

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# WELCOME
## TO THE TEAM

We want to welcome you as a caregiver of **Broadway Home Care**. You are joining an agency whose principle goal is to assist our patients in the time of need. We are proud to say that our agency enjoys a fine reputation for the highest standards of care for our patient's. The elevated quality of our services is due in a great part to the concerned dedication of our caregivers. We believe that by working as a team, and maintaining strong communication amongst ourselves, is the reason for our success. We are pleased to have you join our family. We hope your experience working here will be a positive and rewarding one.

To help you become familiar with our agency, we have prepared this handbook. We believe that it is vital that you understand all of our policies and expectations and this handbook will familiarize you with the responsibilities of being a caregiver. This handbook is just a summation of our policies and is in no way meant to be a comprehensive description of every policy and procedure. Should you need clarification on anything, please contact your supervisor. If you have any questions, comments or suggestions, please do not hesitate to contact us.

Once again, welcome to Broadway Home Care
**106 West Main Street, 2nd Floor**
**Johnstown, NY 12095**
Office **518-762-1767**
Fax **518-762-1768**

## WHAT IS HOME CARE?

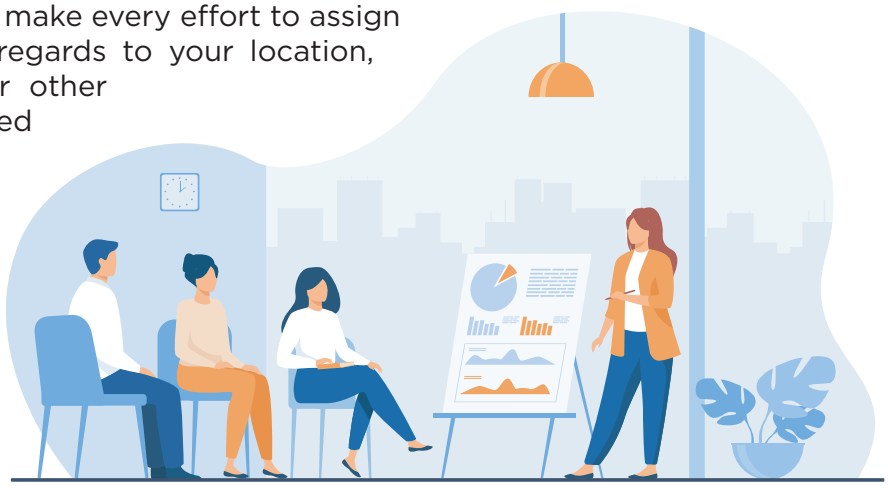
**Home Care are services to the disabled, chronically ill, or recovering person(s) providing for treatment and/or effective functioning in a home environment. Home care can assist in the provision of services to adults and children in danger of abuse or neglect. Home care is appropriate when a person needs assistance that cannot easily be effectively provided by family members or friends for a short or long period of time.**

# JOB ASSIGNMENTS

In accordance with Department of Health requirements, you are only qualified and authorized to accept a job assignment after attending and completing orientation.

All job assignments are made by the Agency Coordinator. In making case assignments, which are solely under our discretion, we take into account various factors, including, but not limited to:

- Special language requirements of a patient
- Contract entity and/or patient requests
- Broadway Home Care determines that a particular caregiver does not fit in with the patient's needs or attitudes
- Another caregiver is better qualified for the position, hours or geographic location
- Geographic location
- Other factors as Broadway Home Care deems appropriate for that assignment



Nonetheless, the Coordinator will make every effort to assign cases most suited to you with regards to your location, availability, and type of case or other stated preference. You are expected to be cooperative and be flexible in accepting assignments. If, however, you cannot accept a particular case, you should tell the Coordinator your reasons for declining the case so that future assignments will be more suitable for you.

Once you have accepted an assignment, we expect you to fulfill your obligation. Do not ask the patient to change her hours for your convenience. If this case does not work with your schedule, you must notify the Coordinator. She/he will then make any necessary changes, even if it means replacing you.

HHAeXchange
Real Time Web-Based Management Solutions for Home Care Agencies & Payers

We now have a mobile app which is used to instantly broadcast many of our available cases. To sign up download the HHAexchange Mobile App available through the App store or Google Play.

# CASE TYPES



**MUTUAL PATIENTS**
A visit in which caregivers provide services to two patients at once.

**LINKED WITH**
A visit in which caregivers provide services to two patients that are typically scheduled as back-to-back visits.

**LIVE-IN**
A 24-hour visit in which the caregiver remains at the patient's residence overnight but where the caregiver works 13 hours (subject to some exceptions).

**HOURLY PATIENT**
This is the common case, where a caregiver services a patient for a few hours and then leaves, without someone coming to relieve him/her.

**24-HOUR CARE PATIENT**
The patient receives 24 hours of care which is split into two 12-hour shifts. (Such a patient may never be left without a caregiver, EVEN if the family is present).

# PROBATIONARY PERIOD

All caregivers are considered probationary for the first 90 days of employment. During the probationary period, the Agency evaluates if you are able to perform your job competently. The probationary period also provides you with an opportunity to decide if you would like to become a regular caregiver with Broadway Home Care. Broadway Home Care may extend the probationary period should circumstances warrant it, in its sole discretion. Neither being in, nor completion of, the probationary period will change the "at-will" nature of your employment in any way.

# REPORTING AND RECORDING

As a caregiver, you will learn how to follow the patient's plan of care. The caregiver is typically the one that notices early changes in the patient's overall condition. The caregiver observes the baseline of what is normal for the patient. Any change in the patient's baseline must be reported immediately. Caregivers are expected to notify the agency of any changes- even if the patient/ family has already done so. Often, caregivers save patients' lives by timely detecting a change in condition that is then reported to the agency or if necessary 911. Timely reporting of any observed change in a patient's living condition/environment, behavior, nutritional intake, or health should be reported to your coordinator.

If the patient was taken to the Emergency room or was hospitalized, you must report this to your Coordinator immediately. You are not allowed or expected to go to the patient's home if you know they are not there. You can never work for a patient while he/she is hospitalized or in rehab or otherwise not home. Please be advised that attempting to report work time when you know that the patient was not home, and you were not required or expected to work for the patient is tantamount to Medicaid fraud and will be investigated. You may be immediately terminated if it is determined that you attempted to report work time for such situations.

**HEALTH CARE HEROES SAVE LIVES**
by noticing the ***small changes*** in their patients!

# STARTING A NEW CASE

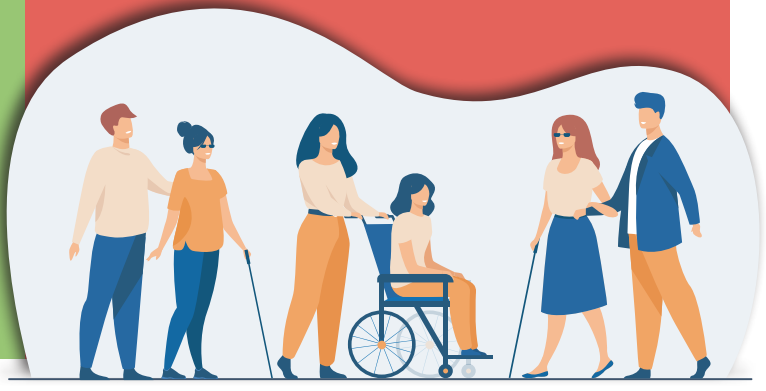
The Coordinator will contact you with all relevant information about the patient. This includes dates, times and location. She/he will give you as much information as the agency has on each patient. The Coordinator will also review the patients' plan of care with you.

## Do's

- ✓ Schedule changes through the designated Coordinator.
- ✓ Coordinate any work through the agency so we know when you are working and can pay you according. Unauthorized hours /visits will not be paid for.
- ✓ Contact your coordinator if your client is not home or you are turned away upon arrival. Another case will try to be given to you which you must accept.
- ✓ Bring your own meals to your clients home. Most clients have limited income so please be considerate and refuse their offerings.
- ✓ Be aware of different cultures and adhere to them i.e Kosher homes.
- ✓ Eat before or after your shift if you are working 6 or less hours.
- ✓ Call the Coordinator if you are working more than 6 hours so arrangements can be made for breaks/lunch/ dinner time.
- ✓ Clock out and have your timesheet signed BEFORE you leave the client's home.
- ✓ Contact your Coordinator if you need to leave the client's home for a personal emergency.
- ✓ Have your ID badge on you at all times.
- ✓ Dress appropriately according to office regulations.
- ✓ Stay professional at all times.
- ✓ Provide 2-week written notice along with a reasonable explanation if you wished to be removed from a case due to a difficult client.

## Don'ts

- ✗ Do not take it upon yourself to make changes without authorization (this can result in your removal from the case).
- ✗ Do not have an unauthorized individual cover your case. This will result in the case not being paid and your termination.
- ✗ Do not assume your client is not home if they do not answer the door. Call the coordinator and do not leave until you have been authorized to do so.
- ✗ Do not use your or any car to drive your client anywhere. This could result in you being personally sued.
- ✗ Do not leave the client's home if you are allotted breaktime. The break will need to be taken at the client's home.
- ✗ Do not leave the client's home until your shift is over, unless you are doing an errand for the client.
- ✗ Do not be in the client's home if the client is not present. If the client leaves his/her home you must contact your coordinator immediately and leave at the same time.



# SCHEDULING

**All live in cases are priority one.** These patients must never be left alone even for 5 minutes, unless authorized by your supervisor. Even for errands and shopping, you must also call your coordinator for notification and approval.

**Be prepared to stay longer** than expected in case of an emergency.

Make sure to **write down dates and times of your patient's medical appointments**, that way they do not miss any appointments.



# KEEP IN MIND...

| TAKE YOUR | SHOWER DAILY | CHANGE INTO | MAKE SURE | DO NOT TALK | ALWAYS | DO NOT EAT |
|---|---|---|---|---|---|---|
| food, clothes and toiletries to last your schedule (pack your things in a clean luggage). | and do not forget your deodorants (presentation is very important). | your pajamas at night (only for night time not during the day). | you are appropriately dressed during working hours. | too loud on the phone, avoid chatting on the phone when your patient is awake. | address your patient and family members as Ms., Mrs., or Mr. | the patient's food or use your patient's phones to make long distance calls. |

# NUTRITION



Make sure your patient eats breakfast, lunch and dinner every day. Also make sure your patient drinks enough fluids. If your patient is not eating well, you must call your Coordinator and inform him/her.

Make sure your patient is sitting up for all meals.

If you think your patient is losing weight, you must call your Coordinator and inform him/her.

# NUTRITION



Watch your patient for any changes in their weight loss or gain. If you notice a change, call your coordinator and notify them.

Make sure your patient is sitting up for all meals (avoiding choking or aspiration, this can lead to lung infection and possible death).

Make sure your patient eats breakfast, lunch and dinner every day. Also make sure your patient drinks enough fluids. If your patient is not eating well, you must call your coordinator and inform them.

# PLAN OF CARE

You are under the direct supervision of a registered nurse on all cases. Prior to your arrival on a case, a professional nurse will visit the patient to evaluate the physical and emotional needs of your patient. Once the evaluation is complete, the nurse will develop a plan of care with the patient. The plan of care will explain exactly what your patient's needs are and what your duties will be under that plan of care. It is very important that you perform only the duties authorized by that plan of care. You are not permitted to change the plan of care or the duties. If you do, you may be disciplined, including termination.

If you observe any changes in your patient's condition, you must report such a change to your coordinator, so amendments can be made. If you are asked to do something that is not specified on the nurse's care plan by the patient or their family, please call your Coordinator.

The duties on the plan of care should be reflected on your time slip. You cannot falsify the duties performed on a shift.

The Nurse is available for you to discuss any problems as they arise regarding the plan of care, and to help find solutions to those problems. Home visits are made to assure that the patient's needs are being met. Also, the nurse will evaluate you and ensure that you are following the plan of care in a safe and efficient manner.



# SKIN CARE AND HYGIENE

If your patient uses diapers, make sure you change them frequently as needed. Apply a barrier cream to the unbroken skin as needed to prevent diaper rash.

You must check your patient's skin and report any sores, ulcers, bruises, cuts, swelling and black and blue marks.

Please bath or assist your patient in bathing or showering. If your patient refuses to shower or does not cooperate during showers, please call and inform your coordinator.

If your patient is chair or bed bound, you must turn and position your patient every 2-3 hours or as indicated in the plan of care to prevent skin break down.

Please change patient into pajamas for bedtime and change into day clothes during the day.



# HOUSEKEEPING



PLEASE SWEEP THE HOUSE DAILY, MOP AND VACUUM AS NEEDED.



CHANGE LINENS AT LEAST ONCE A WEEK, AND AS NEEDED.



KEEP BATHROOM, KITCHEN AND ALL LIVING AREAS TIDY AND CLEAN AT ALL TIMES.



LAUNDRY SHOULD BE DONE AS NEEDED BUT AT THE MINIMUM, DONE WEEKLY.



# ACTIVITIES

## If you need assistance with any of the following, please call your coordinator

**...operating the hoyer lift**

**... using the wheelchair**

**...transfering your patient:**
**from the bed to the wheelchair**
**from the bed to the commode**
**from the wheelchair to the commode**



# GUIDELINES FOR LIVE-IN CASES

## CAREGIVER TO BE AWARE



1. Take your food, clothes, money (for transportation) and toiletries to last your schedule. (Pack your things in a clean luggage)
2. Shower daily and do not forget your deodorants. (Presentation is very important)
3. Change into your pajamas at night. (Pajamas is only for night time, not during the day)
4. Make sure you are appropriately dressed during work hours.
5. Do not talk too loud on the phone. Avoid chatting on the phone when your patient is awake.
6. Always address your patient and family members as Ms., Mrs., or Mr.
7. Do not eat your patient's food or use your patient's phone to make long distance calls.

# ADMINISTRATION OF MEDICATION

Broadway Home Care does not dispense (give out, divide, cut, crush or administer) any medications, both prescription and non-prescription.

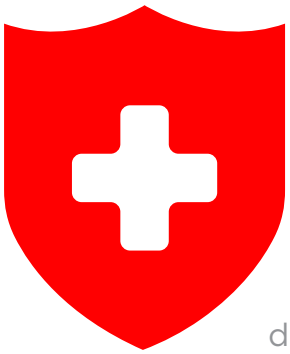
- ✕ Cannot pour medication/pills.
- ✕ Cannot spoon feed/place medication in mouth.
- ✕ Cannot remove pills from the medication bottle, but you can assist the patient to remove from a pre-poured medication box if directed in the POC.

## A CAREGIVER CAN ASSIST WITH SELF-ADMINISTRATION OF MEDICATION.

"ASSISTING" includes reminding the patient when to take medications, reading the label for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container, positioning the patient for medication administration, providing appropriate fluid for swallowing medication, storing, cleaning and disposal of used supplies and equipment, and storing medication properly. "SELF-DIRECTING" means that the patient can make choices about his/her activities of daily living. The patient understands the impact of the choice and assumes responsibility for the results.



# SAFETY GUIDELINES FOR WORKING IN THE HOME



Caregivers shall not be required to work in any situation that would threaten or endanger his/her health or safety. The caregiver shall immediately report to their Coordinator any working conditions that threaten or endanger the health or safety of the caregiver or patient. No caregiver shall suffer any discipline or negative job consequences as a result of reporting an unsafe work situation. Caregivers shall contact their Coordinator in the event of an emergency.

No caregiver shall be required to provide, at his/her own expense, protective garments to perform any task for a patient. The Agency maintains an adequate supply of protective garments at the branch location. Caregivers are responsible for securing these items prior to servicing their patient. If such a situation arises where there are insufficient protective garments, the caregiver will report the situation immediately to his/her Coordinator.

When going to a home for the first time, take a few minutes to think about the kind of home it is, and what problems you are likely to run into while there. You must expect the unexpected and be prepared for it.

Some, but not all, precautions and factors you should consider include:

- **SIDE RAILS ON THE BED SHOULD BE UP**
- **YOUR PATIENT SHOULD BE SAFELY POSITIONED AT ALL TIMES TO A BED OR CHAIR**
- **WHEN GETTING YOUR PATIENT UP, WATCH FOR SIGNS OF DIZZINESS AND WAIT UNTIL IT PASSES BEFORE LETTING THEM STAND**
- **WHEELCHAIR BRAKES SHOULD BE LOCKED WHEN STANDING STILL**
- **SMOKING IN BED SHOULD BE DISCOURAGED OR, IF NECESSARY, MUST BE SUPERVISED**
- **THE ROOM SHOULD BE KEPT CLEAR OF EXTRA EQUIPMENT ESPECIALLY AT NIGHT**
- **MAKE SURE SHOES ARE KEPT WELL TIED AND WORN FOR HOUSEHOLD ACTIVITIES**
- **MAKE SURE HAZARDOUS TOOLS ARE KEPT LOCKED**

# HANDLING MONEY

- **PREPARE AN ESCAPE PLAN IN CASE OF FIRE, WITH ALTERNATE ROUTES TO SAFETY AND MAKE SURE EVERYONE IN THE HOME KNOWS WHAT TO DO**
- **ABOVE ALL, USE COMMON SENSE WHEN APPROACHING ALL JOB AND TASKS**

When shopping for the patient remember to write down the amount of money your patient gives you and return with a register receipt and the exact change. Have the patient sign everything. The document indicating how much money they gave you, the receipt, and how much change they received. All of this should total up and equal the amount originally received. You will be responsible for any lost or unaccountable money.



You may not accept access to the patient's bank account (this includes the debit card and pin number) without authorization from the Coordinator.



# TRANSPORTING PATIENTS

**PATIENTS CANNOT DRIVE CAREGIVERS ANYWHERE.** There are some allowances for a caregiver to drive their patient. Please speak to your Coordinator about how to get this arranged, if needed.

# CAREGIVERS CHANGE OVER

**INTRODUCTION:** Say your name and show your ID badge.

**ROUTINE:** Review the patient's routine with the other caregiver at the case.

**POC (PLAN OF CARE):** Review the POC with the other caregiver and with the patient.

**MEALS:** Review the patient's preferred meal time and diet with the other caregiver.

**EQUIPMENT:** Review with the other caregiver how to use the patient's hoyer lift, wheelchair, walker, etc.

**PERSONAL CARE:** Review with the other caregiver the showing/ bathing and dressing routine; any specific preferences.

**FAMILY MEMBER'S INFORMATION:** As the other caregiver for family member's information, in case needed.

# PATIENTS RECEIVING 24 HOUR CARE



## Responsibility

A patient that receives 24-hours of care is considered a high priority patient. If you agree to accept a high priority patient, whether a live-in case or a 12-hour shift, please be aware that there is a higher level of responsibility associated with this case.

## Scheduling

1. It is crucial to show up **on time**, as you will be relieving the caregiver who is currently on the case.
2. Since a patient receiving 24-hours of care may **NEVER** be without a caregiver, the shift may be extended past the original scheduled end time. This means that in case of an emergency, you might be asked to stay at the patient's home longer than originally scheduled.
3. If you have prior commitments that will prevent you from being available to stay past the shift end time, the **coordinator** should be notified.
4. The agency must know who is with the patient at all times. **Communicate** any change in the schedule with the agency.

**You may not leave the patient's home before a relief caregiver arrives unless you obtain authorization from the agency.**

*LEAVING A 24-HOUR CARE PATIENT ALONE IS CONSIDERED "PATIENT ABANDONMENT."*

## Backup Plan

**《A》** In the event that the relieving caregiver has not shown up:

- **a)** Contact the agency immediately.
- **b)** You may be asked to extend you shift until coverage is found.
  ➲ The agency will work on securing a replacement caregiver to relieve you.
- **c)** If there is a specific time by which you cannot stay past, please make this clear when communicating with the agency.
- **d)** You can leave the case as soon as the coordinator calls you back and gives you the authorization to leave.

**PLEASE NOTE:** Leaving the case prior to receiving authorization from the coordinator (even if you informed her that you need to leave) is considered "leaving a case without authorization/patient abandonment".

**《B》** In the event of a true medical emergency that requires the caregiver on the case to leave immediately before the end of the shift:

- **a)** Call the agency or have someone call the agency immediately.
- **b)** Clearly specify that this is a medical emergency that needs immediate response.

## Service

A patient who receives two (2) 12-hour shifts, requires care throughout. Even the caregiver doing the overnight may never sleep.

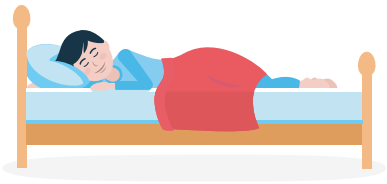
# LIVE-IN CASE RULES



You will be paid for all hours worked on a 24-hour/live-in shift. During each full 24-hour period during which you are required to be on duty, you agree that you will receive Bona Fide Meal Periods of up to 3 hours total and a Bona Fide Sleep Period of up to 8 hours, and that these hours (total of 11) will not count as hours worked. All other hours during the course of such 24-hour period will be considered hours worked and you will be paid at the applicable rates for such work.

**"BONA FIDE MEAL PERIODS"** are meal periods (e.g., one each for breakfast, lunch, and dinner) that are uninterrupted, duty free, and at least 30 minutes in duration. While you may not leave the premises, you shall leave your work area during each of your Bona Fide Meal Periods. You are not required to eat with the patient during your meal period or take your meal period during the same time that the patient eats his/her meal.

**"BONA FIDE SLEEP PERIODS"** are regularly scheduled sleep periods, which include at least 5 consecutive hours that are not interrupted by a call to duty, in adequate sleeping facilities.



It is expected that you will only be required to work for 13 hours of the entire 24-hour shift you are assigned to be with the patient. It is expected that you will enjoy a total of at least 3 hours of Bona Fide Meal Periods as well as an 8-hour Bona Fide Sleep Period for each full 24-hour shift. Where you receive a total of at least 3 hours of Bona Fide Meal Periods as well as an 8-hour Bona Fide Sleep Period, you will be credited with 13 hours of work for the 24-hour shift.

**"ADEQUATE SLEEPING FACILITIES"** means that you have access to basic sleeping amenities (e.g., a bed and linens); enjoy reasonable standards of comfort (e.g., heat); and have access to basic bathroom and kitchen facilities, which may be shared (e.g., bathing and toilet facilities, refrigerator, stove, sink, utensils).

If you "live-in"[1] at the home of the patient, "adequate sleeping facilities" means private quarters (i.e. a living and sleeping space that is separate from the patient or other caregivers) in a homelike environment (i.e. a space that includes facilities for cooking and eating, a bathroom, and a space for recreation (these additional facilities may be shared by you and the patient and/or other household members).

To ensure that you are paid for all hours you work, you will be asked to certify on each timesheet whether or not you have received at least a total of at least 3 hours of Bona Fide Meal Periods and/or at least an 8-hour Bona Fide Sleep Period for each full 24-hour shift. If you do not receive a Bona Fide Meal Period or a Bona Fide Sleep Period on any one shift, you must (a) contact your Coordinator as soon as possible following the conclusion of the shift at issue (generally, not later than within 24 hours following the end of the shift); and (b) complete a "Sleep and Meal Period Exception Certification Form" and return the form to your Coordinator as soon as possible (generally, within 72 hours of the shift). A blank Sleep and Meal Period Exception Certification Form is set forth in the Appendix to this Handbook and additional forms are available from any Coordinator.

If you believe that you were not paid for all hours worked that you identified on a Sleep and Meal Period Exception Certification Form or otherwise, you must contact the Human Resources Department immediately and report the actual hours that you worked so that you can be compensated for all of your hours worked.

No caregiver will be subject to any reprisal or other adverse action for reporting missed or interrupted meal or sleep periods or for submitting a Sleep and Meal Period Exception Certification Form. But any caregiver who knowingly submits a false report or Sleep and Meal Period Exception Certification Form will be subject to disciplinary action, up to and including termination of employment.

[1] You "live in" if you reside at your worksite on a "permanent basis" (i.e., you stay there seven nights a week and have no other home of your own), or for "extended periods of time" (i.e., you work and sleep there five days a week (120 hours or more) or five consecutive days or nights (regardless of the total number of hours).

# CERTIFICATION FORM

## SLEEP AND MEAL PERIOD EXCEPTION

Employee Name (Print): _____

Date of Shift: _____

I attest that during my shift on the date noted above:

I did not have access to adequate sleeping facilities. Explain: _____

_____

_____

I did not receive a duty-free, uninterrupted sleep period of at least 5 consecutive hours. Explain:

_____

_____

_____

I received a duty-free, uninterrupted sleep period of at least 5 consecutive hours, but did not receive a duty-free, uninterrupted 8-hour sleep period. Specifically, my sleep period was interrupted by a call to duty for a total of _____ hours. Explain: _____

_____

_____

I did not receive a total of at least 3 hours of Bona Fide Meal Periods. Instead, I only received a total of hours of Bona Fide Meal Periods (do not include in this figure any duty-free, uninterrupted meal periods you were able to take that were less than 30 minutes in duration). Explain: _____

_____

_____

I certify, under penalty of perjury, that the information contained in this Sleep and Meal Period Exception Certification Form is true, accurate, and complete.

_____ _____

Signature Date

# HOSPICE CARE

HOSPICE CARE FOCUSES ON THE QUALITY OF LIFE FOR PATIENTS WHO ARE EXPERIENCING AN ADVANCED NON-CURABLE, LIFE-LIMITING ILLNESS. HOSPICE CARE PROVIDES COMPASSIONATE CARE FOR PEOPLE IN THE LAST PHASES OF INCURABLE DISEASE SO THAT THEY MAY LIVE AS FULLY AND COMFORTABLY AS POSSIBLE.

IF A PATIENT IS ON HOSPICE CARE, IT WILL BE NOTED ON THE PLAN OF CARE. ANY PATIENT CHANGE IN CONDITION OR INCIDENTS MUST BE REPORTED TO YOUR COORDINATOR AND THE HOSPICE NURSE.

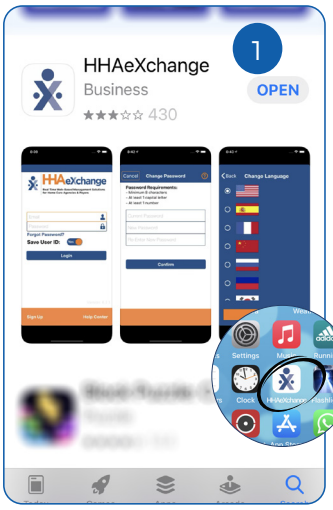


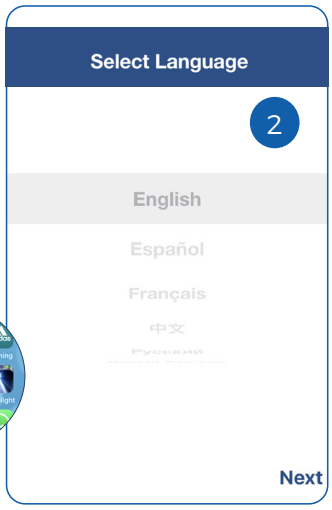
# HHA EXCHANGE SETUP PROCESS

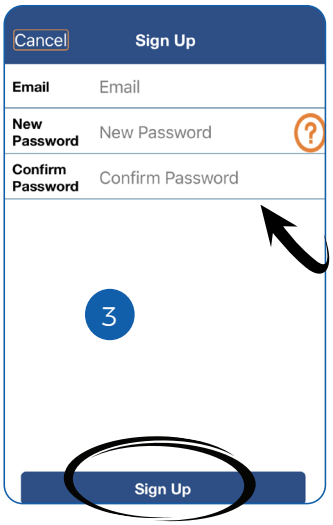
1. Download **HHAeXchange** App from app store and install. Make sure to **allow notifications** when asked
2. Select preferred **Language**
3. Click "**Sign Up**" or go to step 10 if you already have an account.
4. Enter personal **e-mail** and create **password** and then click "**Sign Up**"
5. Check your **e-mail** for confirmation and then log back into the app with the account you just created
6. Click "**Terms Accepted**" on Terms of Use
7. Click **3 dots** on the top right corner
8. Choose "**Update Profile**"
9. Fill in **ALL** fields accurately and click **Create**
10. **Record the Mobile ID** and give Mobile ID number to Agency trainer *(have them clear out the old code, if one was there previously)*

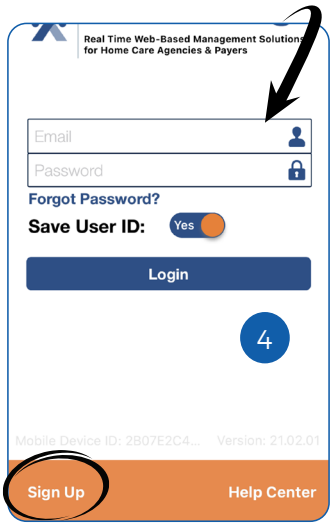
Nurse updates Exchange. Caregiver: Log in again now and **you are all set**!

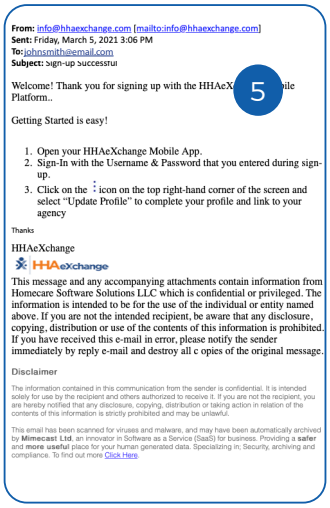
For **password resets**, click on "**forgot password**" to get a **TEMP** password sent to your personal e-mail account

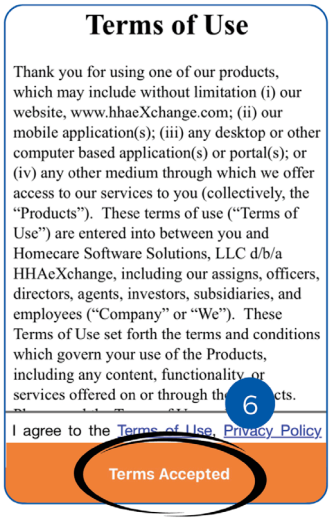


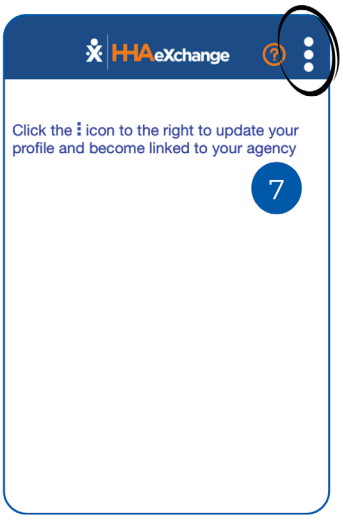



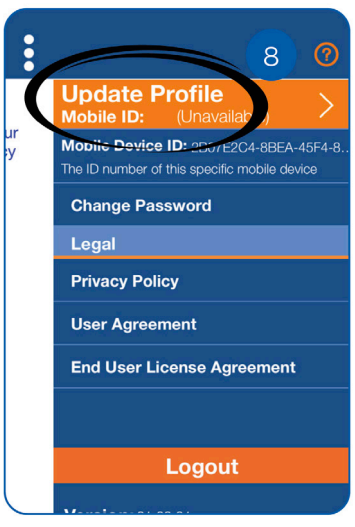



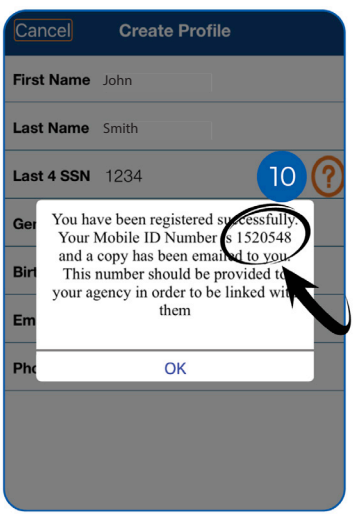









# OFFICE HOURS AND LOCATIONS

## MAIN OFFICE

**518-762-1767**

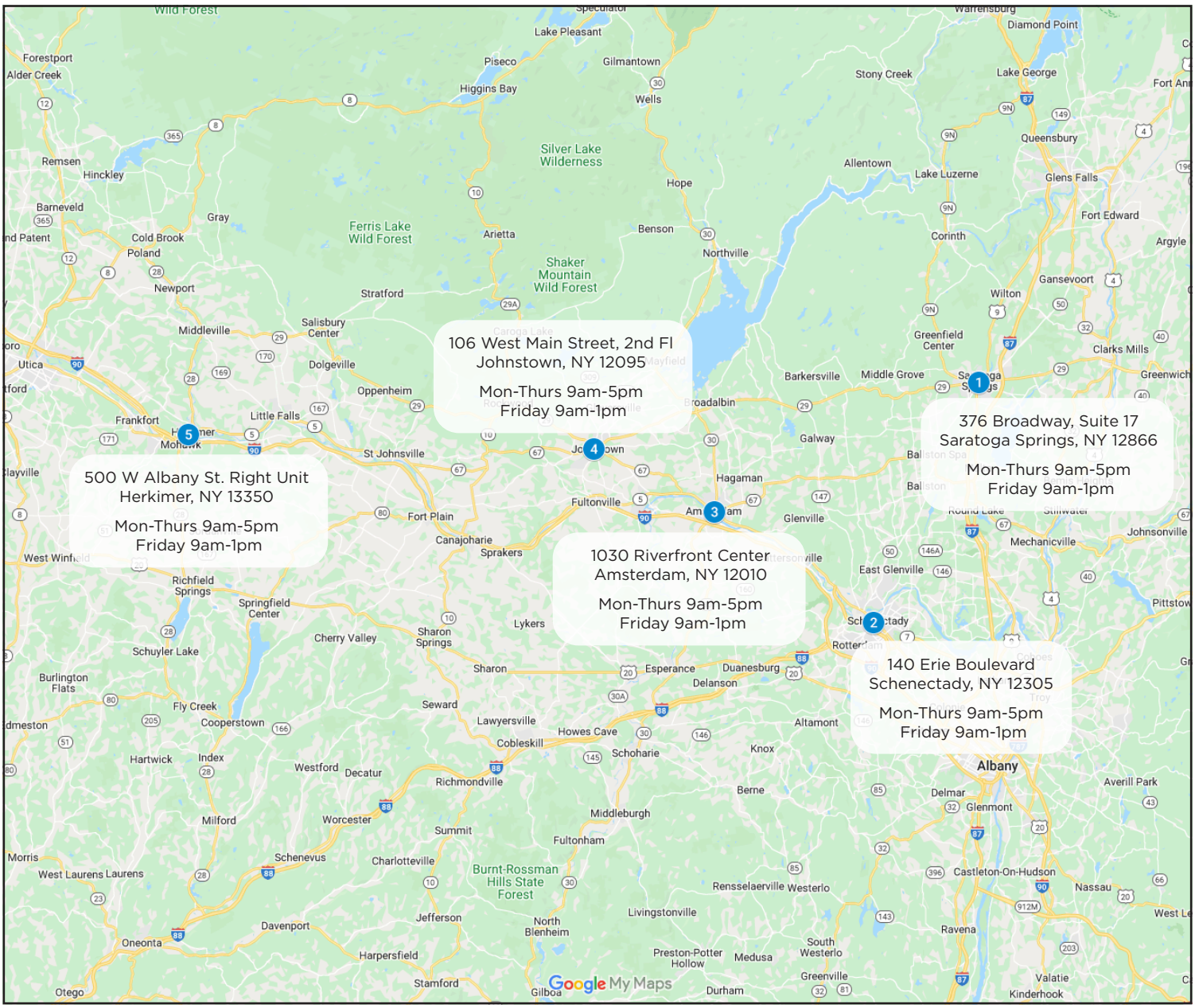
*DIAL "0" TO REACH AN OPERATOR 24/7*

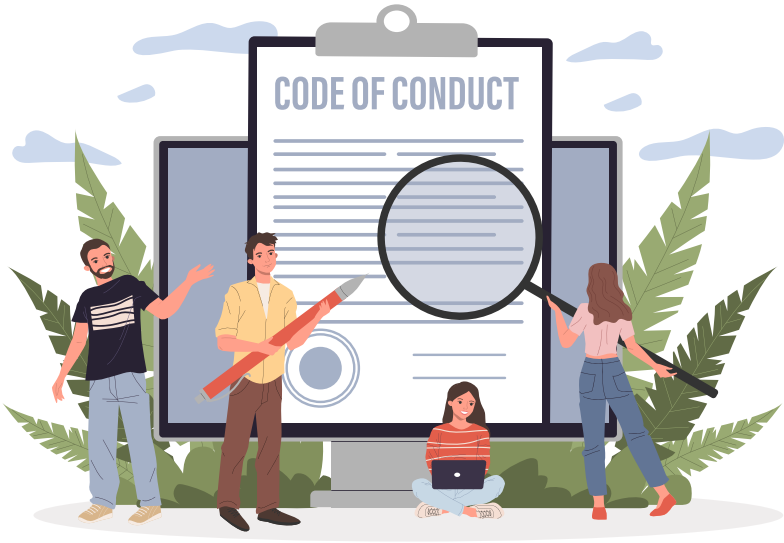
106 West Main St, 2nd Floor, Johnstown, NY 12095
Monday - Thursday: 9:00am-5:00pm Friday: 9:00am-1:00pm

81 Prospect Street, Unit 715, Brooklyn, NY 11201

1 Hillcrest Center Drive, Suite 201, Spring Valley, NY 10977

## RECRUITING OFFICES ONLY






To function effectively, every organization must develop policies and procedures to protect its patients and to ensure that co-workers' and the business's rights are respected. Broadway Home Care is no exception. Generally, conduct that violates our policies, including those outlined in this Handbook, or that may be unethical and/or illegal will not be tolerated.

While this Handbook cannot describe every possible situation or instance, below is a non-exhaustive list of the types of conduct for which the Agency would impose strong disciplinary action or even immediate termination:

1. Patient abuse/neglect or failure to report suspected abuse/neglect
2. Stealing or attempting to steal employer, caregiver, or patient property
3. No-call, no-show
4. Insubordination or failure to obey reasonable instructions from a patient or from Broadway Home Care
5. Violation of our No Smoking Policy, Drug and Alcohol Policy, Confidentiality Policy, Code of Ethics, or other policies outlined in this Handbook
6. Patient abandonment
7. Violation of HIPAA or state law regarding disclosure of confidential patient information
8. Excessive absenteeism or tardiness
9. Falsifying employment, legal, or other records, including time sheets and records of care, or other forms of dishonesty
10. Neglecting job duties during working time
11. Physical fighting or violence (actual or threatened) on employer or patient property at any time
12. Demonstrating incompetence or poor or sloppy work quality
13. Using offensive or profane language, especially towards or in the presence of patients or patients' family members
14. Sleeping in the patient's home
15. Violation of Broadway Home Care's policies prohibiting discrimination, harassment, and retaliation
16. Refusing to work required overtime
17. Bringing friends or family into the patient's home
18. Bringing dangerous or unauthorized weapons into patient or Agency premises
19. Caregivers are required to be professional in their communication with patients and agency staff, and to cooperate with investigations.

The above list is not-exhaustive, and the Agency may discipline or terminate a caregiver for any reason. In addition, the Agency may choose to impose any form of discipline it deems appropriate under the circumstances, including termination for even a first violation.

CAREGIVERS WHO ARE TERMINATED BY THE AGENCY FOR DISCIPLINARY REASONS OR POOR PERFORMANCE ARE NOT ELIGIBLE FOR REHIRE.

# APPEARANCE AND DRESS CODE



Your appearance reflects the kind of person you are and the quality of work you do. Appropriate, neat, clean clothing must be worn. The following are examples of DO'S and DON'TS

## Do's

**SLACKS OR CAPRIS**

**SKIRTS KNEE LENGTH OR LONGER**

**SCRUBS**

**HAIR NEATLY TIED BACK**

**SOLID SHOES OR SNEAKERS**

**SLEEVED SHIRTS**

## Don'ts

**SHORTS**

**MINI SKIRTS**

**TANK TOPS**

**DO-RAGS**

**FLIP-FLOPS, HIGH-HEELS, SANDALS**

**HALTER TOPS**

**TATTERED JEANS OR CUT OFF**



Your body should be clean and free of odor, please use deodorant. No strong perfume or aftershave should be used. Hair must be clean and neatly combed. Long hair should be fastened back and off the shoulders. Fingernails should be clean and reasonably short. Excessive jewelry is not permitted. Identification badges are provided by the Agency and must be worn at all times. If you require modifications of our dress code standards due to religious reasons, please speak to your Coordinator and inform them of the precise reason that you are requesting the modification. If reasonable, such requests may be granted by the Agency.

**YOU WILL BE SENT HOME IF YOU ARE NOT PROPERLY ATTIRED.**

# PHOTO ID CARD

**In accordance with New York State Health Department regulations, Broadway Home Care is providing you with a Photo Identification card. This identification card must be worn on your clothing at all times while you are working.**

**Lost or stolen cards must be reported to HR immediately. Failure to wear your ID badge or excessive loss or damage to cards can lead to disciplinary action up to and including termination.**

**Your identification card must be returned to the Agency upon termination of your employment.**



# WORKPLACE ADMINISTRATIVE SEARCHES

To assist in providing a reliable, efficient and productive work force for the proper care of patients, to assist in providing caregivers with a safe working environment, to assist in the effective operation of the Compliance Program and to supplement the Drug and Alcohol Policy, supervisors may conduct unannounced administrative searches of Agency premises, offices, work areas, property and equipment and the contents of such property and equipment. No caregiver should have any expectation of privacy on the Agency property or in their offices or work areas including lockers, desks, cabinets, drawers, shelves or trash cans or in folders, envelopes or packages located on Agency premises. In addition, searches of temporary space of live in caregivers at patients of the Agency may be subject to a search at the discretion of the Agency as a result of a complaint of a patient whose property is occupied. Personal possessions or materials should not be brought to work if they are of a sensitive or confidential nature. The Agency policy on Workplace Administrative Searches may be obtained from the Department of Human Resources or designee. Other policies permit monitoring of and access to computers by supervisors. The use of computers, e-mail and access to the Internet must be reasonable and responsible.

# WHILE WORKING WITH PATIENTS

## LOITERING/VISITING



Caregivers are required to leave the premises of the patient's home or facility upon completion of scheduled shift. Caregivers cannot live with the patient unless they are on a live-in case or have a special exemption from the agency

Never bring children, family, friends or pets to your patient's location. Under no circumstances should anybody visit you while you are working. This is a DOH violation and will result in termination.

## TIPPING, SOLICITING & GIFTS



Caregivers are forbidden to engage in unauthorized solicitations such as subscriptions, catalogs, fund-raisers, petitions, etc.

Caregivers are not to accept gifts, money, clothing, food, etc. This includes borrowing money from a patient's family. We also forbid the solicitation of money/gifts from fellow caregivers.

Caregivers are forbidden from doing any form of business transactions with patients.

## ALCOHOL, DRUGS & SMOKING



To ensure a safe and productive work environment, the Agency prohibits the use, purchase, sale, possession, or transfer of any alcoholic beverage or nonmedically prescribed controlled drug while on agency property, patient property or scheduled working hours. Broadway Home Care has a zero-tolerance policy regarding alcohol, drugs, and smoking (including e-cigarettes / any vaping devices). Arriving to work under the influence of drugs and/or alcohol will result in immediate termination.

The Agency also prohibits caregivers from reporting for or being at work while under the influence of alcohol or drugs. Caregivers who are using a prescribed drug which might in any way affect job performance should report to the agency. The full drug and alcohol policy can be found at the end of this handbook. You are not allowed to smoke in the patient's home, even if they are a smoker.

# DRUG AND ALCOHOL POLICY



To help ensure a safe, healthy and productive work environment for all caregivers, patients and their families and others, the Agency has adopted a policy maintaining a workplace free of drugs and alcohol. This policy restricts certain items and substances from being brought to the workplace and prohibits caregivers from reporting to work or working under the influence of illegal drugs, alcohol and other controlled substances which may affect their ability perform work safely. A caregiver who feels that he/she has a substance abuse problem is encouraged to seek professional help. The Agency will also offer referral service to any caregiver who voluntarily requests help.

This policy includes pre-employment, post-incident, reasonable suspicion and annual testing as well as searches and investigations to the extent permissible by law.

## RULES

1. Processing, manufacturing, distribution, dispensing and/or the use of illegal drugs, drug paraphernalia, unauthorized controlled substances, illegal use of legal drugs and other intoxicants during work hours or in work areas is prohibited.

2. Reporting to or being at work under the influence of illegal drugs or unauthorized controlled substances are prohibited. Reporting to and being under the influence of alcohol or other legal intoxicant that can adversely affect a caregiver's performance or the safety of the caregiver, those surrounding the caregiver is also prohibited.

3. Legally prescribed drugs may be permitted provided that the drugs are prescribed to the caregiver by an authorized medical practitioner for current use by the employer. Reporting to and being at work under the influence of prescribed or over-the-counter drugs, where such use prevents a caregiver from performing the duties of the job or poses a safety risk to other persons or property is prohibited. Caregivers taking a prescription over-the-counter drug are personally responsible for confirming with their physician that they may safely perform any job duties while taking such items. Caregivers taking a legal substance that could impair their safe work must advise their immediate supervisor, who may assign the caregiver to non-hazardous duties or send them home. A caregiver's failure to notify their supervisor at the start of their work shift will result in disciplinary action up to and including termination of employment.

4. The possession or use of alcohol during work hours or in a patient's home is prohibited.

5. Nothing set forth in this policy shall be construed as limitation upon the right to terminate a caregiver at any time and upon any reason and the right of the caregiver to resign at any time for any reason.

6. Any caregiver who is found to be in violation of this policy will be subject to discipline up to and including termination.

# ARGUMENTS



In the event that a patient or family member communicates in an argumentative manner, do not argue back, and do not abandon the patient. Call the office ***immediately***, either from their home phone or walk outside, and use your cell phone. If you feel threatened by the patient or any visitor in their home, please call the Coordinator immediately. The Agency is committed to providing a safe workplace for you and you will not be allowed to stay in a home if you have reasonable concerns about your safety.

In a calm manner, describe to the Coordinator what is taking place or what has occurred. The office will direct you as to what actions must be taken.

Be prepared to come into the office directly after your shift. A written report explaining the incident must be prepared and documented. Your signature and wording will be required at this time. It is important that this is done as soon as possible so that the report is accurate (within 24 hours).

# TELEPHONE CALLS

No personal calls are to be made from the patient's phone except for patient related business. For example, reporting to your Coordinator changes in patient's condition, patient care questions, 911, calls to M.D. office, etc. If there is an emergency call to be made, please reverse the charges to the person you are calling. If your family needs to reach you please give them the office phone number and a message will be passed on to you.

**DO NOT GIVE YOUR HOME PHONE NUMBER TO THE PATIENT OR PATIENT'S FAMILY. YOU CAN ANSWER THE PATIENT'S PHONE IF YOU ARE WORKING**



Cell phones should be turned off before you enter your patient's home. Do not answer your cell phone while caring for a patient. You may check your cell phone during break time or when your shift is over.
**When on a steady case, you must return calls to the agency.**

Please note once removed from a case there is no personal communication (calls or texts) with the patient. Please reach out to the agency if any of your belongings were left behind.

# CRIMINAL ACTIVITY




All of our caregivers are required to go through the CHRC program (Failure to show up to the agency scheduled CHRC meeting without prior notification will be grounds for discipline up to and including termination.) - which requires a detailed background check via the Department of Health. If a caregiver is arrested, we may be required to put you on administrative leave pending our review of the circumstances related to the arrest. We will consider various factors, such as the nature of the alleged offense, and/or the caregiver's explanation of the circumstances and their job responsibilities, when determining how the arrest affects your employment, if at all.

# STEALING

We will not tolerate theft from the Agency, patient or family. We will make every effort to support any caregiver who is unjustly accused of stealing.

If you are accused of stealing property from the patient, we will conduct a fair investigation. Caregivers are expected to cooperate in such investigations and answer any questions. Refusal to participate in such investigation or lying to a supervisor in the course of the investigation will be grounds for termination.

If it's established through our investigation that a caregiver is guilty of stealing, we will refer the case to law enforcement. You may also be reported for theft by the patient and their family. Be aware that the agency will cooperate with the local, state and federal law enforcement agencies in theft investigation including sharing any requested caregiver information as required and permitted by law. Likewise, we reserve the right to report you to the home care caregiver registry for any egregious misconduct, such as theft.



# TARDINESS

Tardiness or failing to report to work as scheduled can be problematic for the patients. If a caregiver is sick or is going to be late, he/she must call the office main phone number at **845-425-6555** (Dial extension 0 for an operator. Please note, if you reach a voicemail box you should call again to reach the operator). When calling, be sure to identify the reason for calling off or reporting to work late. If you don't show up on time, as scheduled, or if you call the agency that you will be late to the shift, we reserve the right to cancel your shift and secure a replacement for the client if your lateness or absence will place the patient at risk for danger or compromise patients safety. If you are working in New York City and you are calling off or reporting late due to one of the reasons protected by the New York City Safe and Sick Time Law, please follow our policy in this Handbook, which requires you to notify your Coordinator that you are absent or late due to one of the reasons covered by the Law.

**Do not call out to your patient directly. You are employed by the Agency, not the patient.**

**You MUST NOT arrive late or leave early unless approved by the Agency.**

**Excessive and repeated tardiness without proper reasons will lead to termination.**

**You must not arrive late or leave early unless approved by the agency in advance.**

**3 call outs in a 30-day period is considered frequent and results in a lack of consistency in patient care, and will be grounds for discipline.**

# SOLICITATION AND DISTRIBUTIONS

In the interest of maintaining a proper business environment and preventing interference with work and inconvenience to others, caregivers may not solicit other caregivers during working time, or distribute literature during working time or at any time in working areas. Persons not employed by Broadway Home Care are prohibited from soliciting or distributing literature on Agency and patient property.

## FOR PURPOSES OF THIS POLICY:

### SOLICITATION

includes, but is not limited to, approaching someone in person or through employer-owned property such as computers, smartphones, e-mail systems, and intranets for any of the following purposes: offering anything for sale, asking for donations, collecting funds or pledges, seeking to promote, encourage or discourage participation in or support for any organization, activity or event, or membership in any organization, or distributing or delivering membership cards or applications for any organization.

### DISTRIBUTION

includes, but is not limited to, disseminating or delivering in person or through employer-owned property such as bulletin boards, computers, smartphones, e-mails, and intranets any literature or other materials including circulars, notices, papers, leaflets, or other printed, written, or electronic matter (except that distributing or delivering membership cards or applications for any organization is considered solicitation and not distribution).

### WORKING TIME

includes any time in which either the person doing the solicitation (or distribution) or the person being solicited (or to whom non-business literature is being distributed) is engaged in or required to be performing work tasks. Working time excludes times when caregivers are properly not engaged in performing work tasks, including break periods and meal times.

### WORKING AREAS

include areas where caregivers are performing work, including patients' homes or premises.

# ELECTRONIC MAIL, SOCIAL MEDIA AND INTERNET

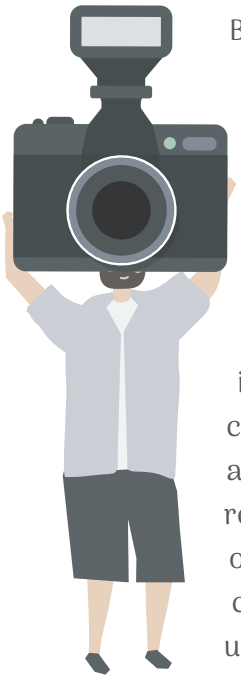
**Some caregivers may use social media websites e.g. Facebook, Linked In, etc. as a medium of self-expression and the Agency respects the right of caregivers to use such sites. However, if a caregiver chooses to identify him or herself on such Internet venues, the following code of conduct is expected:**

Caregivers must be professional, truthful and respectful in all communications and blogs. Caregivers must not use obscenities, profanity, or vulgar language. Caregivers may not use blogs, personal websites or any online platform to disparage the Agency or share any confidential information or information that is considered PHI under HIPAA. Caregivers may not use blogs or personal Web sites to harass or intimidate other caregivers, patients, or patients' families.

Caregivers may not use blogs or personal Web sites to discuss engaging in behavior that is prohibited by Agency policies, including, but not limited to, the use of alcohol and drugs, sexual activity, sexual harassment.




# PHOTO WAIVER AND RELEASE



By acknowledging this Handbook, you hereby consent to and authorize the Agency **(a) taking at any time, in the Agency's discretion, your photograph, whether alone or with other people**, **(b) using and re-using each such photograph in print, electronic or other media, or copies of same** for the Agency's publications, advertising, marketing (including social media marketing), publicity, promotions, public relations, and news media business activities, including, but not limited to, the Agency's website and in the Agency's business development or other promotional materials, including print, broadcast, and electronic media, including social media. You can withdraw this consent at any time by notifying the corporate office. By accepting employment with the Agency, you, and your successors and assigns, release and discharge the Agency from each claim or cause of action arising out of or in connection with its use of your photograph or name pursuant to this consent (including, without limitation, each claim or cause of action arising under Section 50 of the New York Civil Rights Law).

# ABUSE AND NEGLECT REPORTING POLICY

THE AGENCY IS COMMITTED TO THE SAFETY AND WELL-BEING OF ALL ITS PATIENTS. OBSERVING, SCREENING AND REPORTING ABUSE AND NEGLECT IS INCLUDED AT ORIENTATION FOR ALL NEW CAREGIVERS. IN ADDITION, AN IN-SERVICE PROGRAM, "ABUSE AND NEGLECT", IS PRESENTED AS PART OF THE ONGOING IN-SERVICE SCHEDULE.

The following operation definitions are used to assist in determining if patients are victims of abuse or neglect:

### CHILD ABUSE
The physical, sexual or emotional maltreatment of a child, it may be overt or covert.

### CHILD NEGLECT
The failure by parents or guardians to provide for the basic needs of a child by physical or emotional deprivation that interferes with normal growth and development or that places the child in jeopardy.

### ELDER ABUSE
Non-accidental acts of physical or mental mistreatment (including that of a sexual nature) of an elderly or vulnerable adult.

### ELDER NEGLECT
A pattern of conduct or inaction by a person entrusted with caring for an elderly or vulnerable adult that results in deprivation of care necessary to maintain that person's physical or mental health.

As part of the initial and ongoing patient assessments, the Director of Nursing observes for signs of abuse and neglect. Caregivers are encouraged to report observable changes in family dynamics, changes in patient status and any bruising or injury the patient sustains. The patient's support system is identified at time of admission and encouraged to discuss concerns related to the patient. Identification and use of Broadway resources is also discussed to help individuals in the patient's support system in coping with caring for an ill or elderly person.

If there is a reasonable suspicion of abuse or neglect, an incident report is completed, and the situation is discussed with the Administrator. Mandated reporters, i.e., health care professionals are required to **report cases of suspected child abuse or neglect by calling 1-800-635-1522 in New York State**. Non-mandated reporters are to call the New York State Central Registry in Albany at 1-800-342-3720. Reporting is necessary to protect the child and obtain services for the patient(s) to assist in dealing with the actions leading to abuse or neglect. In conjunction with the physician, Adult Protective Services (APS) is contacted if there is concern for the safety and welfare of an adult patient. All actions taken by the Agency's staff regarding reporting and follow-up of suspected or actual abuse and/or neglect are documented in the patient record.

# ADULT PROTECTIVE SERVICES (APS)




The Agency maintains a list of Broadway resources as well as the telephone number for APS. The Agency is committed to the safety of:

**1.** All Agency personnel who come in direct contact with patients receive a complete orientation and participate in on-going training to **recognize potentially hazardous conditions** related to the service they provide.

**2.** Initial and ongoing patient or caregiver instruction on **home safety management** is appropriate to the provider's level of responsibility, as it relates to the patient's needs.

**3.** Home safety management includes the following areas:

- Basic home and bathroom safety
- Fire response and means of emergency exit from home
- Storage of supplies, drugs, controlled substances, solutions and needles
- Transfers and ambulation with assistive devices
- Use of medical equipment and electrical incidents
- Waste disposal *(double boxing, bagging and use of non-penetrable container)*

**4.** Patients and caregivers receive **written instructions** whenever possible.

**5.** Patient/Caregiver **knowledge and performance of safety procedures** are evaluated and documented in an ongoing basis.

**6.** Agency personnel use a **safety checklist** to document existing or potential safety hazards.

**7.** All personnel are knowledgeable of the system for **reporting accidents, injuries and safety hazards**.

**8.** The staff's use of the safety management program is evaluated periodically, and **in- service education** is based on the findings of those evaluations.



# "FAIR" PROGRAM

## FACT-FINDING AND ISSUE RESOLUTION ("FAIR") PROGRAM

1 **Overview of the FAIR Program.** Broadway Home Care values each caregiver and looks forward to good relations with and among all of its caregivers. Occasionally, however, disagreements may arise between you and Broadway Home Care or between caregivers in a context that involves Broadway Home Care. We believe that the resolution of such disagreements will be best accomplished by internal dispute resolution and, where that fails, by binding arbitration that is conducted by an arbitrator. For these reasons, Broadway Home Care Inc. has adopted this Fact- finding and Issue Resolution Program (the "FAIR Program").

2 **Effect of this document.** By singing this agreement, you agree that all "Claims" (as defined below in paragraph 3) between "You" and the "Agency" (as defined below in paragraph 3) shall be resolved exclusively by the internal dispute resolution procedures and the binding arbitration procedures described in this document.

The FAIR Program is an essential element of your employment and, for current caregivers, continued employment with the Agency. Although the FAIR Program is a binding agreement between you and the Agency, it does not create a contract of employment or otherwise affect the at-will nature of your employment. You indicate your agreement to be bound by the FAIR Program's terms and conditions by signing this document.

3 **What Does the FAIR Program Cover?**

a The FAIR Program applies to any and all Claims, regardless of when those claims arose or accrued. For avoidance of doubt, the provisions of this agreement apply to claims that accrued or arose before execution of this agreement and to claims that accrued or arose after execution of this agreement. The provisions of this agreement also apply to Claims that arose after your employment with the Agency ends.

b For purposes of the FAIR Program and this document, the "Agency" and/or "Broadway Home Care" means Broadway Health Aide Services and its parents, subsidiaries, affiliates, predecessors, and successors, as well each of their current and former owners, members, managers, shareholders, partners, directors, officers, caregivers, and agents.

c "You" and "Your" refers to you and any other person who may assert your rights.

d "Claim" includes any claim, dispute, allegation, controversy, or action between You and the Agency that in any way arises from, or relates to, your employment with the Agency or the termination of your employment with the Agency, regardless of that Claim accrued or arose. A Claim encompasses, for example,

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any employment, labor, wage-and-hour, overtime, and compensation claims, including, without limitation, any Claim that may arise under the following laws:

- Title VII of the Civil Rights Act of 1964
- The Civil Rights Act of 1991
- The Age Discrimination in Employment Act of 1967
- The Americans with Disabilities Act of 1990
- The Fair Labor Standards Act of 1938 or any state wage and hour laws, such as the New York Labor Law
- New York Public Health Law Section 3614- c, also known as the Wage Parity Law
- The Rehabilitation Act of 1973
- The Older Workers Benefit Protection Act
- The Family and Medical Leave Act of 1993
- The Occupational Safety and Health Act of 1970
- The Worker Adjustment and Retraining Notification Act of 1988
- Any state anti-discrimination, anti- retaliation, or whistleblower laws (including, without limitation, the New York State Human Rights Law and the New York State Whistleblower Law).
- Any other federal, state, or local statute, regulation, or common-law doctrine regarding employment, employment discrimination, harassment, terms and conditions of employment, termination of employment, compensation, breach of contract, or defamation.
- Disputes about the validity, enforceability, coverage or scope of the FAIR Program or any part thereof.

**The above list is not exclusive and is only provided to illustrate examples of Claims**

## Are any Claims excluded from this FAIR Program?

The term "Claim" does not include the following, which are for a court or an agency and not an arbitrator to decide:

- Controversies, claims or other disputes for injunctive relief for unfair competition or unauthorized use or disclosure of confidential information or trade secrets.
- Claims for workers' compensation (except that claims for interference with or retaliation for filing a workers' compensation claim will be considered a Claim subject to arbitration under the FAIR Program).
- Claims for unemployment compensation benefits.
- Claims for caregiver welfare benefits (e.g., medical, health, dental).
- Claims for retirement benefits under the Caregiver Retirement Income Security Act ("ERISA") (except that claims for interference with or retaliation for exercising protected rights under ERISA shall be considered Claims subject to arbitration under the FAIR Program).
- Unfair labor practice charges under the National Labor Relations Act.

The FAIR Program does ***not*** prevent you from filing a charge, testifying, assisting, or otherwise participating in any investigation or proceeding conducted by the equal employment opportunity commission, or another government agency to the extent that You have a protected right to do so. But if you take such action in relation to a



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claim, controversy, or other dispute that would constitute a Claim and you have not fully pursued such dispute through the FAIR Program, the Agency may request the agency in question to defer its processing or investigation of such charge until the FAIR Program has been completed. Notwithstanding your rights under this subsection, you agree that, to the maximum extent permitted by law, You may recover monetary relief with respect to a Claim only through the FAIR Program.

Further, the FAIR Program does not require the Agency to begin arbitration proceedings or initiate any other procedure before taking any action regarding your employment with which you might disagree, such as coaching, counseling, warning, reprimand, suspension, investigation, discipline, demotion, changing your days or hours of work, or termination.

4 **Can a Claim Be Resolved in Court? No.** Under the FAIR Program, You and the Agency each waive your respective rights to have a Claim decided by a court, judge, jury and, where permitted by law, an administrative agency. Instead, You and the Agency hereby agree that the internal dispute resolution and arbitration procedures set forth below are the sole and exclusive methods for resolving any and all Claims.

5 **Submitting a Claim Under the FAIR Program?** If You believe that You have a Claim against the Agency, You should first give the Agency a chance to investigate and resolve the Claim before You file a demand for arbitration (the arbitration process is explained further below). You do not need to use any specific form to submit a Claim. Simply write a letter explaining your Claim and the relief sought and submit the Claim letter to the Human Resources Manager. If You do not receive a response from the Agency within 30 days of the date that you submitted Your letter to Human Resources, or you disagree with the response from the Agency, and you wish to pursue the Claim further, You must submit your Claim exclusively to binding arbitration with the American Arbitration Association ("AAA") in accordance with the AAA's Employment Arbitration Rules and Mediation Procedures.

6 **How Much Time do You Have to File a Claim?** An arbitration proceeding must be commenced within the time period prescribed by the statutes of limitations applicable to the Claim being asserted. For purposes of statute of limitations, an arbitration proceeding is deemed commenced when a demand for arbitration is filed with the AAA.

7 **How Does the Arbitration Process Begin?** To start the arbitration process, the party wishing to file a Claim must file a written demand in accordance with the rules of the AAA for starting the arbitration process. More information about the AAA may be obtained at www.adr.org or by calling 1.800.778.7879.

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8 **How Is the Arbitrator Selected?** Arbitrators will be selected by the parties in accordance with the AAA's Employment Arbitration Rules and Mediation Procedures. The arbitrator must be a licensed attorney, or a retired judge selected from the AAA's Employment Arbitration Rules and Mediation Procedures Employment Dispute Resolution Roster, or a similar list if such list is unavailable. Unless the parties agree otherwise, the arbitrator must be a retired or former judge or a lawyer who has at least 5 years of experience with employment-related claims.

9 **Can an Attorney Represent You? Yes.** Any party may be represented by an attorney. If you need assistance finding an attorney, there may be resources available to you, such as the **American Bar Association** (www.americanbar.org and 800-285-2221 or 202-662-1000) or the **Legal Aid Society** (www.legal-aide.org and 212-577-3300 or 718-722-3100).

10 **When and Where Will the Arbitration Hearing Take Place?** The arbitration hearing will be conducted by the arbitrator in whatever manner will most expeditiously permit full presentation of evidence and arguments of the parties. The arbitrator will set the time, date, and place of the hearing, notice of which must be given to the parties at least 30 calendar days in advance, unless the parties agree otherwise. Any arbitration hearing will take place within Rockland County, State of New York, unless the parties agree otherwise.

11 **What Rules and Law Apply to The Arbitration?** Arbitration under the FAIR Program will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures, except that under no circumstances will an arbitrator have the authority to hear or decide any Claim on a class, collective, or other group or representative basis. The arbitrator must apply the substantive law, including the applicable burdens of proof and persuasion, that would be applied by a court hearing the Claim in the venue of the arbitration. The arbitrator may grant relief that could be granted by a court hearing the Claim, including an award of attorneys' fees and costs.

12 **Can Claims Be Heard on A Class, Representative, Or Collective Basis? No.** Notwithstanding anything to the contrary: (a) no arbitrator is permitted to hear or decide any Claim on a class, collective, or other group or representative basis; (b) all Claims between You and the Agency must be decided individually; and (c) the AAA's Supplementary Rules for Class Action Arbitration (and any similar rules) will not have any applicability to any Claim. This means that if You have a Claim, neither You nor the Agency will have the right, with respect to that Claim, to do any of the following in court



or before an arbitrator: (a) pursue or obtain any relief from a class, collective, or other group or representative action; (b) act as a private attorney general; or (c) join or consolidate a Claim with the Claim of any other person. Thus, the arbitrator shall have no authority or jurisdiction to process, conduct, or rule upon any class, collective, private attorney general, or other representative or group proceeding under any circumstances. If there is more than one Claim between You and the Agency, those Claims may be heard in a single arbitration.



13 **Who Pays for The Arbitration?** The party claiming to be aggrieved is responsible for paying the applicable filing fee in effect and established by the AAA at the time the demand for arbitration is made. If You file the demand for arbitration and cannot obtain a waiver of the filing fee, You can ask the Agency to pay the filing fee. The Agency will review every such request in good faith and consider whether to cover all or part of such filing fee.

The arbitrator will charge a fee for his/her services and his/her costs. The parties will equally share the arbitrator's fees and other costs of the arbitration. However, if sharing equally in the cost of the arbitrator's fees would cause you financial hardship, You can ask the Agency to pay, in full, the arbitrator's fees and other costs. The Agency will pay all of the arbitrator's costs and fees as necessary to implement this FAIR Program. Each party will be responsible for its own attorneys' fees and costs, but the arbitrator may award either party reasonable attorneys' fees and costs in accordance with the applicable law.

14 **Are the Parties Entitled to Discovery or Depositions? Yes.** All discovery will be governed by the AAA rules.

15 **Can You have Witnesses Testify at The Arbitration? Yes.** At the hearing, the parties will have the right to present proof through testimony and documentary evidence, and to cross-examine witnesses who testify at the hearing. The arbitrator will require all witnesses to testify under oath. The arbitrator(s) will also have the authority to decide whether any person who is not a witness may attend the hearing.

16 **The Arbitrator's Decision/Award.** The Arbitrator will issue his or her award promptly after the arbitration hearing concludes or post-hearing briefs are received. The arbitrator's award will set forth the factual and legal basis for the award, including his or her legal reasoning, and contain a summary of the facts, the issues, the governing law applied, and the relief requested and awarded. It must also identify any other issues resolved and the disposition of any statutory claims. The arbitrator's award will

be final and binding on the parties.

17 **How Long Does the FAIR Program Apply to You?** The FAIR Program will remain in effect and survive the cessation of Your employment relationship or affiliation with the Agency, regardless of the reason for such cessation.

18 **Miscellaneous Provisions Regarding the Fair Program:**

**Choice of Law:** The FAIR Program and the terms of this agreement shall be governed by the Federal Arbitration Act ("FAA"). The parties acknowledge and agree that the FAIR Program evidences a transaction involving interstate commerce.

**Severability:** If any part or provision of the FAIR Program or this agreement is held to be invalid, illegal, or unenforceable, such holding will not affect the legality, validity, or enforceability of the remaining parts, and each provision of the FAIR Program and this agreement will be valid, legal, and enforceable to the fullest extent permitted by law. However, in the event the provision prohibiting class, collective, or representative actions is found to be unlawful or unenforceable, then the entire FAIR Program and this agreement will be considered null and void.

**Notices:** Any notice required to be given to You will be directed to Your last known address as reflected in the records of the Agency. Any notice required to be given to the Agency will be directed to the Administrator at 33 Downtown Dr, 3rd Floor, Monsey, NY 10952.

**Amendment:** The Agency reserves the right to amend or terminate the FAIR Program. Such amendments may be made by providing notice to You, electronically or in writing, of such amendment or termination.

**Waiver:** No waiver may be granted by either party, except in writing. No waiver of any provision of the FAIR Program will constitute a waiver of any other provision of the FAIR Program (whether or not similar), nor will such waiver constitute a continuing waiver unless otherwise expressly provided in such writing.



By signing the Handbook Acknowledgment of Receipt, You confirm that You have read and understand the terms and conditions of the FAIR Program, which require You to submit all Claims to binding arbitration on an individual basis. No provision of any other document You may receive from the Agency will be construed as a waiver of the provision prohibiting class, collective, or representative actions.

# DEALING WITH CONFLICT

Everyone has had to deal with difficult people or situations at one time or another. Learning to deal with the conflict through better listening and communication skills can be the key to solving the problem at hand.

## CONFLICT RESOLUTION

- Stay calm.
- Do not escalate the situation. It is not important to feel like you have to win a verbal argument. If a situation develops, please contact your agency for support.
- Listen to the person presenting the conflict. He/she should feel that you are interested and willing to help.
- Confirm that you heard and understood.
- Assess the situation.
- Identify the problem.
- Describe the problem briefly and accurately to your designated contract person, i.e. family/supervisor/coordinator.



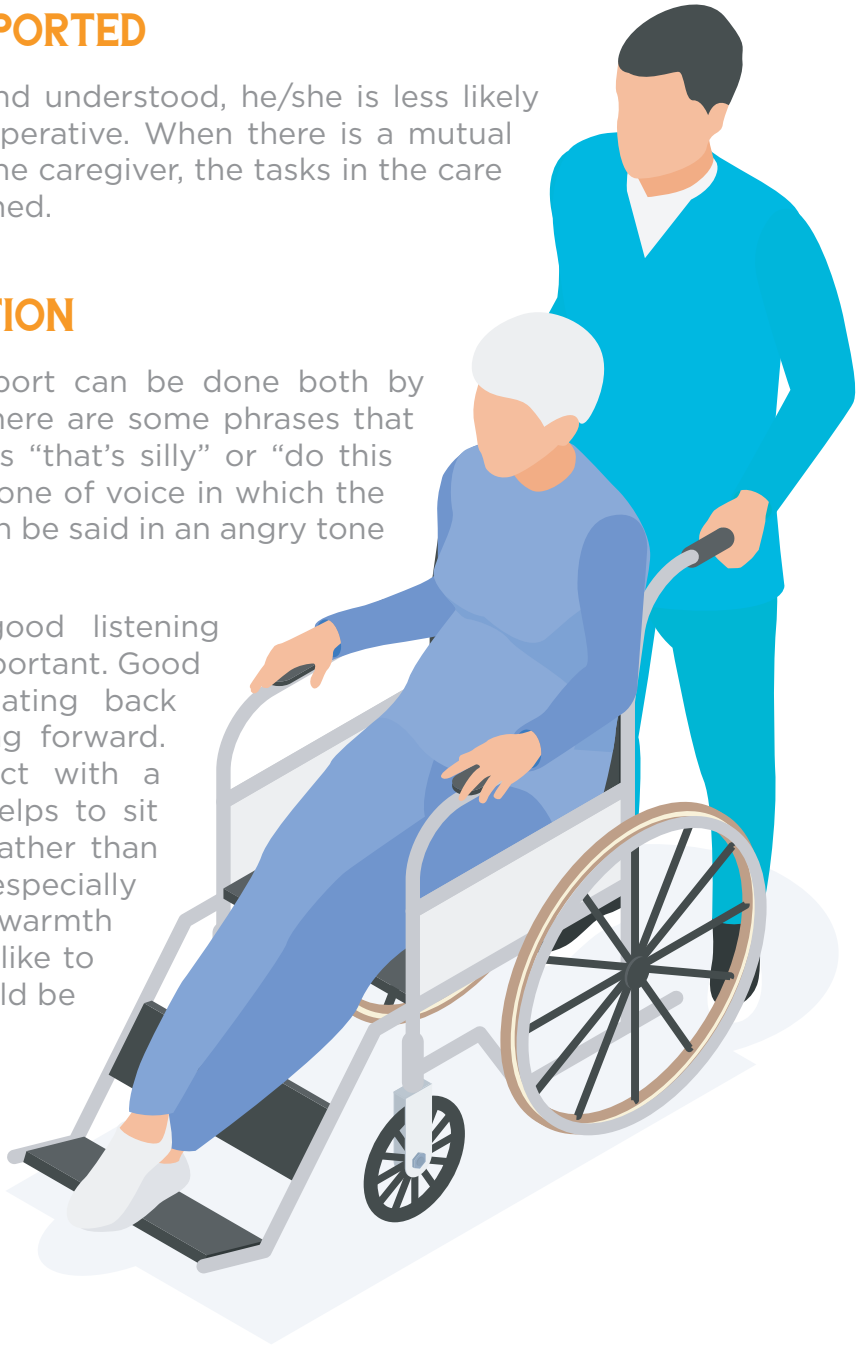
# INTERPERSONAL RELATIONSHIPS

## SUPPORTIVE RELATIONSHIPS

The relationship between the caregiver and the patient is one of the most important elements in a successful home care situation. There are certain behaviors that will promote communication and convey caring to a patient. Everyone wants to be listened to, cared about, accepted, liked, respected, understood and regarded as capable or competent.

## PATIENTS MUST FEEL SUPPORTED

When a patient feels respected and understood, he/she is less likely to be destructive, angry or uncooperative. When there is a mutual respect between the patient and the caregiver, the tasks in the care plan will be more easily accomplished.



## SUPPORTIVE COMMUNICATION

Communicating respect and support can be done both by what is said and how it is said. There are some phrases that will upset almost anybody such as “that’s silly” or “do this or else.” Equally important is the tone of voice in which the words are said. A simple phrase can be said in an angry tone that contradicts the words.

Non-verbal behavior such as good listening habits or body language is also important. Good listening includes nodding, repeating back what the patient says and leaning forward. Facial expressions convey respect with a smile and attentive behavior. It helps to sit next to someone who is sitting, rather than standing over him/her. Touch, especially with the elderly, help to convey warmth and interest. Some people do not like to be touched and their feelings should be respected.

You must keep communication open and positive through your tone of voice facial expressions and body posture.

# CULTURAL DIVERSITY

**THE CAREGIVER WILL HAVE MANY PATIENTS WITH CULTURAL BACKGROUNDS AND TRADITIONS DIFFERENT FROM HIS/HER OWN. YOU HAVE TO REMEMBER TO RESPECT AND VALUE EACH PATIENT AS AN INDIVIDUAL.**

## DIVERSITY & INCLUSION

CULTURAL BACKGROUND CAN INFLUENCE A VARIETY OF SITUATIONS, FOR EXAMPLE:

- **> HOW FRIENDLY YOUR PATIENT IS TOWARD STRANGERS**
- **> HOW THEY FEEL ABOUT HAVING YOU OR ANYONE ELSE IN THEIR HOME**
- **> HOW CLOSE THEY WANT YOU TO STAND TO THEM WHEN TALKING TO THEM**

THE RELIGION OF A PATIENT AND HIS/HER FAMILY CAN ALSO AFFECT THE WAY THEY BEHAVE. RELIGION CAN BE VERY IMPORTANT TO THE PATIENT WHO IS VERY ILL OR DYING. AS A CAREGIVER, YOU HAVE TO **RESPECT THESE DIFFERENCES, EVEN IF THEY ARE VERY DIFFERENT FROM YOUR OWN**. NEVER QUESTION THE PATIENT'S RELIGION, AND REFRAIN FROM DISCUSSING YOUR OWN RELIGIOUS BELIEFS. BE AWARE OF AND HONOR ANY DIETARY RESTRICTIONS YOUR PATIENT MAY HAVE BASED ON RELIGIOUS BELIEFS. DISCUSS WITH THE NURSE, PATIENT AND FAMILY ANY MEAL PLANNING AND FOOD PREPARATION ADJUSTMENT AS NEEDED. KEEP PHYSICAL CONTACT TO A MINIMUM FOR THOSE PATIENTS WHOSE CULTURAL OR RELIGIOUS BACKGROUNDS MAKE THEM LESS COMFORTABLE TO BEING TOUCHED. YOU STILL NEED TO CARE FOR THE PATIENT BUT TALK TO THE NURSE ABOUT WAYS TO REDUCE UNNECESSARY TOUCHING. BE SENSITIVE TO YOUR PATIENT'S CULTURAL AND RELIGIOUS BACKGROUND. **TREAT ALL PATIENTS WITH DIGNITY AND RESPECT**. EXPECT YOUR PATIENTS TO TREAT YOU RESPECTFULLY AS WELL.



# RULES

A CAREGIVER, TO THE EXTENT CONSISTENT WITH APPLICABLE FEDERAL, STATE AND LOCAL LAWS, WILL BE REQUIRED TO UNDERGO A SCREENING TEST FOR THE USE OF ILLEGAL AND NON-PRESCRIPTION DRUGS, ALCOHOL OR OTHER SUBSTANCES UNDER ANY OF THE FOLLOWING OR OTHER CIRCUMSTANCES WHICH MAY BE DETERMINED BY THE AGENCY UNDER THIS POLICY:

### POST INCIDENT

If you are involved in a workplace incident resulting in personal injury to you, the patient, or others, or damage to property or workplace, or circumstances which could have resulted in personal injury to either the caregiver or others, or damage to property when there is a reasonable suspicion to believe that the incident has occurred due to drug or alcohol use.

### REASONABLE SUSPICION

When there is reasonable suspicion, satisfactory to the Agency's management, to believe that a caregiver is under the influence of illegal drugs, unauthorized controlled substance, alcohol or other intoxicants during work hours or while in the workplace or that the caregiver has reported to work under the influence of illegal drugs, unauthorized controlled substances, alcohol or other intoxicants which could affect the safety of the caregiver and/or others.

### ANNUAL

When the Agency, upon its discretion, requires screenings on a yearly basis in addition to any other screen that was given in that year.

Any caregiver who tests positive for drugs or alcohol and who believe the test results are incorrect, may request a retest of the original specimen at his/her cost.

The Agency reserves the right to search any caregiver or property for illegal drugs, drug paraphernalia, unauthorized controlled substance, alcohol or other intoxicants. Agency may have a third party complete the search(es). This shall include, but is not limited to, clothing, personal effects, vehicles, buildings, offices, parking lots, desks, cabinets, locker, closets, lunch boxes and equipment.

Caregivers who refuse to submit to testing as required by the Agency or who fail to complete the test will be subject to discipline, up to and including immediate termination of employment. Job applicants who refuse to submit to drug and alcohol testing will be deemed to have withdrawn themselves from the application process and will no longer be considered for employment.

# COMPLAINT PROCEDURES



Questions or problems concerning your job should be brought up with your Coordinator. It is expected that most difficulties will be satisfactorily resolved in this way. If for some reason, a matter you discussed with the Agency staff is not resolved to your satisfaction, we have an open door policy, which means that you can discuss any issues with the next level, a director. If at this time you are still not satisfied with the decision, you may file a complaint with your Coordinator and request that it be submitted to the Board of Directors. This review will take place and be answered within a reasonable amount of time (not to exceed 30 days). The decision rendered by the Board of Directors will be final.

You will find a complaint form on page 68. You may also submit a complaint on any piece of paper you have available. Please send all complaints to the Quality Assurance Department.

For complaints that allege a violation of the law, you are required to follow the FAIR program if you are not satisfied with the Board of Directors' response. Thus, where your complaint alleges a violation of the law, and the Board has rejected your complaint, you are required to follow the FAIR Program if you wish to pursue your complaint and the complaint alleges a violation of some law.

# GENERAL EMPLOYMENT RULES



You are the direct provider of care to our patients and represent our agency to the patient, family and friends. Because you work in the patient's home, we expect you to adhere to our high standards of personal conduct at all times. We expect you to use good judgment, common sense, and a high regard for the rights of the patients in your care.

**In your patient's home, you are not a guest**. You are there to provide services for the patient. Here are some important rules to know when working at Broadway Home Care.

Upon hire, you must work a case within 30 days to avoid termination. After working on an initial case, caregivers must work on a case every 45 days. Failure to work on a case every 45 days will result in termination. To avoid termination for not working in over 45 days you must contact your coordinator or the HR department and provide a legitimate/valid reason for not working.

## EMPLOYMENT AT WILL

We are happy to welcome you to the Agency. We sincerely hope that your employment here will be a positive and rewarding experience. However, we cannot make any guarantees about your continued employment. Your employment here is at will. This means that you are free to quit at any time, for any reason. We are also free to terminate your employment at any time, for any reason with or without notice, with or without cause. No caregiver or the Agency's representative, other than the CEO or Administrator has the authority to change the at will employment relationship or to contract with any caregiver for different terms of employment. Nothing in this Handbook constitutes a contract or promise of continued employment.

## IMMIGRATION COMPLIANCE

In compliance with the federal Immigration Reform and Control Act of 1986, as amended, the Agency is committed to employing only individuals who are authorized to work in the United States. Accordingly, each new caregiver, as a condition of employment, must complete the Employment Eligibility Verification Form I-9 and present acceptable documentation establishing identity and employment eligibility.

If a caregiver is authorized to work in this country for a limited time, the individual will be required to submit proof of renewed employment eligibility prior to expiration of that period to remain employed by the Agency.

## NONSOLICITATION OF PATIENTS

As a caregiver with our organization, you will be provided with high level training and access to confidential information about our patients and their families. You will be placed in a position of trust and confidence with our patients and their families and, due to the goodwill that our organization has developed with our patients, you will be readily accepted by our patients into their homes. The Company has spent considerable time and money to develop the goodwill of its patients, grow its patient services, and expand the number of patients being serviced. Similarly, the Company has invested significant resources into developing its training and supervision curriculum to ensure that all caregivers provide the highest level of care and services to patients.

The Company would be irreparably harmed if a caregiver were to leave the Company's employment and accept private and direct employment with a patient of the Company. For this reason, as a condition of being hired and working for the Company, the caregiver agrees that he/she will not, for one year from the date that he/she terminates employment with the Company: (a) accept direct employment with a patient of the Company or (b) accept employment or a contract with a third party (such as the family of a patient or another home care agency) whereby, as a condition of such employment, the caregiver would service the same patient that the caregiver serviced while working for the Company. This restriction will only apply with respect to patients with which the caregiver worked at any time while employed by the Company. The intent of this provision is to ensure that caregivers maintain their employment with the Company but, should they choose to leave employment with the Company, that they do not solicit or improperly poach those patients from the Company.

Should a caregiver seek out or accept private and direct employment with a patient and/or their family within one year of terminating employment with the Company, the caregiver agrees to pay $5,000 to the Company as liquidated damages.

# HIPAA



HIPAA stands for Health Insurance Portability and Accountability Act. It is a federal law whose purpose is to protect the privacy of personal medical information that is shared with doctors, nurses, hospitals, insurance companies and other health care providers.

HIPAA's Privacy Rule puts new limits on how personal medical information is used and shared, gives patient the right to access their medical records and puts greater protection on those medical records. In the past, personal health information was sold or shared to make decisions regarding employment, for marketing purposes, to coordinate care for disease management and to help determine drug costs. This was done without notice to or consent of the patient. The Privacy Rule applies to all forms of personal health information – written, electronic or oral.

## WHO HAS TO FOLLOW THE HIPAA RULES?

**ALL HEALTHCARE PROVIDERS** – doctors, nurses, caregivers, insurance companies, health care agencies, hospitals, laboratories and business associates of these persons must follow the HIPAA rules.

## WHAT IS PERSONAL HEALTH INFORMATION?

Personal Health information includes any information regarding the past, present or future physical or mental health or condition of a person that is used for treatment or payment of healthcare. The HIPAA rules include additional information that is protected by the privacy rule – any information that can be used to identify individuals. This might be the name, social security number, address, health insurance numbers, doctor's name, diagnosis, etc. This information can connect a person to specific health information.

Protected Health Information (PHI) is that personal health information that is transmitted or stored electronically or in any form other than hard copy.

## WHAT DOES THE AGENCY HAVE TO DO TO MEET THE REGULATIONS?

The Agency must do several things in order to fulfill its legal obligations. We must provide patient and caregiver education about the privacy rights and how patient information can be used. Policies and procedures must be developed for the patient and caregiver to follow. All caregivers must be trained about the policies and procedures. Most important of all, caregivers must be aware of the way that they contribute to the maintenance of patient confidentiality – not discussing cases with people who are not involved in the patient's care, keeping records secure and out of the sight of people who do not work for the agency, properly destroying patient documents that are no longer needed or pieces of paper that have patient information written on them, disclosing only the minimum amount of information that is needed, taking other measures to protect patient confidentiality such as learning about practices.

## WHAT INFORMATION DOES THE PATIENT NEED TO KNOW?

Patients will be informed of the new privacy rule and their rights under this rule, through a "Notice of Privacy Rights". The nurse will give this document to the patient at the time of the first nursing

visit and will ask the patient to sign a consent form to use and share the PHI for treatment, payment and health care operations. This consent form must be kept on file for six years.

## HOW CAN PHI BE USED AND DISCLOSED LEGALLY?

In order for patient to receive treatment, have the treatment paid for by their insurance company and for the health care agency to operate, protected health information (PHI) must be used and disclosed by the people involved in the care of the patient. PHI is used when it is shared, examined, applied and analyzed. PHI is disclosed when it is released, transferred or accessed in any way outside the health care agency. PHI may be used or disclosed in the following instances: for treatment, payment or health care operations; with authorization or agreement from the patient; for disclosure to the patient; for incidental uses such as doctors talking to patients in a hospital room or on the phone or a nurse who is taking care of the patient. For other uses or disclosures, the patient must sign a special authorization form.

## WHAT REQUIREMENTS ARE RELATED TO THE SPECIAL AUTHORIZATION FORM?

This form must be signed by the patient when information must be used or shared with a third party for purpose not related to treatment, payment or health care operations. The authorization may be revoked by the patient at any time. Each authorization must give a specific description of the information to be used or shared, the name of the person who is getting the information, the purpose of the disclosure, the date of expiration of authorization and it must be written in plain English. The information that is shared must be the minimum necessary.

## ARE THERE OTHER TIMES WHEN PHI CAN BE DISCLOSED WITHOUT OBTAINING A SPECIAL AUTHORIZATION?

Yes, PHI may be legally disclosed without obtaining a special authorization from the patient for the purpose of audits, civil and criminal investigations, law enforcement, judicial and administrative proceedings, reporting public health and safety and suspected/known cases of abuse, neglect or domestic violence and other legal requirements. In emergency circumstances PHI may be disclosed. PHI may also be shared with relatives, coroners and medical examiners.

## CAN I TELL IF THE PATIENT SAYS I CAN?

Disclosure may be made to family members, friends or other people that patients indicate is involved in their care or payment of health care unless the patient objects in whole or part. In any other situation not described previously, you need to get the patient's written authorization to disclose any PHI.

## WHAT IF "THEY" ARE LISTENING?

An incidental use or disclosure is a secondary use of disclosure that cannot reasonably be prevented, is limited in nature and occurs as a result of an otherwise permitted use or disclosure. They are permitted only to the extent that reasonable safeguards have been applied and do not disclose any more of the PHI than is necessary to accomplish the permitted use or disclosure – this is known as the Minimum Necessary Standard. An example might be the disclosure about a patient by a home health aide in the patient's home that might be overheard by the other family members not involved in the patient's care.

# HIPAA

### WHAT IS "MINIMUM NECESSARY RULE"?

Use or disclosure of PHI must be limited to the smallest amount that is needed to get a job done. This means that not all caregivers may have the same amount of information about a patient. Each caregiver should have only the information that is necessary for them to carry out their job. This rule does not apply to use or disclosure of medical records for treatment purposes since the health care provider needs access to the entire record to provide quality care.

### WHAT HAPPENS IF AN INDIVIDUAL OR AGENCY FAILS TO FOLLOW THESE LAWS?

Failure to comply may result in civil and/or criminal penalties.

### DOES HIPAA TAKE PRECEDENCE OVER OTHER EXISTING CONFIDENTIALITY LAWS?

In cases where state laws are stricter than the HIPAA rules, the state laws take precedence. An example is the HIV confidentiality laws.

### DOES HIPAA HAVE ANY OTHER PART BESIDE THE PRIVACY RULE?

Yes, there are three parts to the HIPAA regulations. You have already heard about the Privacy Rule. HIPAA also sets standards for the electronic transmission of PHI in order to standardize how this is done throughout the country. There will also be a Security Rule which will create standards governing the security of protected health information (PHI); these regulations have not been written yet.




# AIDS/HIV




New York State regulations forbid the release of confidential information. This includes AIDS/HIV related information. Only the appropriate designated person has the rights to such information and is not required to disclose such information. Therefore, you should always use universal precautions on every patient since you may not know whether the patient has AIDS.

# HEALTHCARE PROXY

Advanced directives protect the patient's rights to make his/her own choices; legal, valid decisions concerning future medical care and treatment. Caregivers must abide by patient advanced directives.

Types of advanced directives include:

**DO NOT RESUSCITATE (DNR): THIS IS A WRITTEN INSTRUCTION TO HOSPITAL/HOME PERSONNEL CONCERNING WHAT ACTIONS TO TAKE IF A TERMINALLY ILL PATIENT SUFFERS A CARDIOPULMONARY ARREST (HEART AND BREATHING STOPS)**

**LIVING WILL: THIS SPECIFIES WRITTEN INSTRUCTIONS REGARDING WHAT HEALTH CARE IS TO BE GIVEN TO A PATIENT IF THE PATIENT BECOMES INCAPABLE OF MAKING HIS/HER OWN DECISIONS**

**HEALTH CARE PROXY: THIS IS AN INDIVIDUAL WHO IS SELECTED OR APPOINTED BY A PATIENT TO MAKE DECISIONS IF THE PATIENT BECOMES UNABLE TO DO SO FOR HIMSELF/HERSELF. THE PERSON MUST BE EIGHTEEN (18) YEARS OF AGE, MENTALLY COMPETENT AND NEED NOT BE A MEMBER OF THE FAMILY.**

As a health care provider, Broadway Home Care reviews and provides a packet of information on advanced directives to its patients. Patients who have indicated in writing their wish not to be resuscitated once they have passed have this instruction documented in a Living Will. This document is usually posted by a patient's bedside or in an area convenient for anyone to see within the patient's home. If your patient has this document, clarify with the family or your Nurse Supervisor if this document is in place for both the home and hospital or the hospital only. You need not call 911 if your patient has a DNR (Do Not Resuscitate) order. Report directly to your patient's Hospice Nurse or Broadway Home Care for changes in the patient's condition.

If you report to work and your patient is not home, does not answer, or refuses care, please call the office immediately. The office staff will see if a reassignment is available for you that day.

If you report to work or become ill or have an emergency that requires you to leave early, call the office immediately. You will be required to stay with the patient until relief staff arrives.

# CONFIDENTIALITY AND PRIVACY

You are never allowed to discuss any information about your patient with any other person, including your family, friends or co-workers. All information about your patient is confidential and the law prohibits you from disclosing this information to any third-party. Any issue or information related to your cases and patients should be discussed only with your nursing supervisor and/or the Coordinator.

If any person other than the patient wishes to discuss the patient's condition, you must direct them to your Coordinator. Do not give out names, phone numbers or address of any family member of a patient, and do not discuss the medical or physical condition of the patient or family member with any third-party.

If you are experiencing a personal issue while working on a case or are being mistreated by a patient, this should be addressed with your Human Resources Representative. Again, this is not to be discussed with anyone but the correct contact person. If you are not sure which individual you should be reaching out to, simply ask for direction from the Human Resource Representative. She will direct your call to that individual.

Caregivers may also learn Agency business information during their employment. The Agency requires caregivers to agree, as a condition of their employment with the Agency, to preserve the Agency's Confidential Information. This means that caregivers cannot, directly or indirectly, disclose, reveal, publish, or otherwise make available to any person or entity the Agency's Confidential Information. Whenever referred to in this Handbook, "the Agency's Confidential Information" will mean all trade secrets and other information not generally known to the public, in whatever format, whether presently existing or developed in the future, relating directly or indirectly to the Agency's business, including the Agency's intellectual property, products and services of the Agency, the manner in which services are provided, advertised, delivered, or designed, patient lists and patient data, referral lists, business strategies, techniques, plans, contracts, terms of agreements, transactions, potential transactions, work-in-progress, financial information, accounting information, pricing information, credit information, market studies, sales information, revenue, costs, communications, research and development, inventions, designs, studies, plans, specifications, patents, applications for particular technologies, designs, business relationships of the Agency (including proposed relationships with patients or referral sources, suppliers, distributors, licensees and licensors), management systems, sales and marketing plans and strategies, terms of contracts with patients or managed care plans and any other payor of services, referral history of a particular referral source, contacts and information about contacts at payors or referral sources, information regarding pending applications to payors, methods and processes, service delivery information, information concerning the condition, treatment or financial history of a patient, and any protected health information. This list is not exhaustive, and the Agency's Confidential Information also includes other information that is marked or otherwise identified or treated as confidential or proprietary, or that would otherwise appear to a reasonable person to be confidential or proprietary in the context and circumstances in which the information is known or used.

Caregivers may disclose the Agency's Confidential Information in connection with the caregiver's work at the Agency, as required by law, or if an owner of the Agency expressly authorizes such disclosure in writing. Further, as a condition of being employed by the Agency, the caregiver agrees to take all reasonable precautions to safeguard the confidential nature of the Agency's Confidential Information and any other precautions with respect thereto which the Agency may reasonably request. Caregivers will not reproduce or otherwise copy any of the Agency's



# CONFIDENTIALITY AND PRIVACY

Confidential Information other than as required in discharging their duties while employed by the Agency. Caregivers agrees that all of the Agency's Confidential Information shall be the sole and exclusive property of the Agency and its assigns at all times, and caregivers assign to the Agency any rights caregivers may have or somehow acquire in the Agency's Confidential Information.

After a caregiver's employment with the Agency ends, the caregiver will not disseminate any of the Agency's Confidential Information unless such information is generally known in the trade or industry, and such general knowledge is not the result of the caregiver's dissemination of the Agency's Confidential Information and the caregiver provides the Agency with reasonable advance notice of such dissemination. Caregivers agree to provide the Agency with written notice of any and all attempts to compel dissemination of the Agency's Confidential Information at least five (5) working days before complying with any subpoena, order, or any other directive seeking such Dissemination. In situations where it is not possible to provide five (5) working days' notice, caregivers will notify the Agency of any attempt to compel dissemination of the Agency's Confidential Information as soon as possible.

# PERSONNEL FILES



Broadway Home Care maintains an official personnel file for all caregivers. The personnel file includes such information such as the caregiver's job application, record of training, performance appraisals, salary increases and other employment records. Broadway Home Care needs your help in keeping your personnel file accurate and up-to-date. Promptly notify your Coordinator of any changes to your name, home address, telephone number and emergency contact(s).

Personnel files are the property of Broadway Home Care and access to this information is restricted. Generally, only supervisors and management personnel who have a legitimate reason to view information in a file are allowed to do so.

Under no circumstances will Broadway Home Care permit reproduction of a personnel file (either particular pages or the entire contents) or removal of a personnel file from the premises.

CREDIT OR HAVE ANOTHER REASON TO ALLOW OUTSIDERS TO OBTAIN INFORMATION FROM YOUR PERSONNEL RECORD, YOU MUST PROVIDE BROADWAY HOME CARE WITH WRITTEN AUTHORIZATION FOR RELEASE OF INFORMATION

# EQUAL EMPLOYMENT OPPORTUNITY

The Agency is an equal opportunity employer and complies with all applicable federal, state, and local fair employment practices laws. As such, the Agency strictly prohibits and does not tolerate discrimination against caregivers, applicants, contractors, subcontractors, vendors, consultants, or any other person working for the Agency because of race, color, religion, creed, national origin or ancestry, ethnicity, sex (including pregnancy), gender, age, physical or mental disability, citizenship, past, current, or prospective service in the uniformed services, genetic information, or any other characteristic protected under applicable federal, state, or local law. All Agency caregivers, other workers, and representatives are prohibited from engaging in unlawful discrimination. This policy applies to all terms and conditions of employment, including, but not limited to, hiring, training, promotion, discipline, compensation, benefits, and termination of employment. This policy applies at the Agency's offices, at your work site(s), while performing work for the Agency off-site, and at Agency-sponsored or work-related events or activities.



**ANY CAREGIVER OR OTHER WORKER, REGARDLESS OF POSITION OR TITLE, WHOM THE AGENCY DETERMINES HAS SUBJECTED AN INDIVIDUAL TO DISCRIMINATION OR RETALIATION IN VIOLATION OF THIS POLICY WILL BE SUBJECT TO DISCIPLINE, UP TO AND INCLUDING TERMINATION OF EMPLOYMENT.**

If you are subjected to or observe any conduct that you believe violates this policy, you must promptly speak to, write, or otherwise contact your supervisor, the Administrator, or a Human Resources Representative. These individuals will ensure that a prompt investigation is conducted. While you can report at any time, the Agency prefers that you submit your complaint within 30 days of the offending conduct to allow for the most effective investigation possible. Your complaint should also be as detailed as possible, including the names of all individuals involved and any witnesses. You may be asked to confirm your complaint in writing. The Agency will investigate the facts and circumstances of all claims of perceived harassment and will take prompt corrective action, if appropriate. All complaints will be kept confidential to the maximum extent possible and, where appropriate, caregiver making the complaint will be advised of the final disposition of the matter.

# AMERICANS WITH DISABILITIES POLICY

The Agency complies with the Americans with Disabilities Act (ADA), as amended, and all applicable state and local fair employment practices laws and is committed to providing equal employment opportunities to qualified individuals with disabilities.

If you believe you need an accommodation because of your disability, you are responsible for requesting a reasonable accommodation from the Human Resources Department. You may make the request orally or in writing, but in the event of an oral request you may be asked to confirm your request in writing. Requests for accommodations should include all relevant information, such as:

- ✓ **A DESCRIPTION OF THE ACCOMMODATION YOU ARE REQUESTING**
- ✓ **THE REASON YOU NEED AN ACCOMMODATION**
- ✓ **HOW THE ACCOMMODATION WILL HELP YOU PERFORM THE ESSENTIAL FUNCTIONS OF YOUR JOB**

The Agency may ask you to provide supporting documents showing that you have a disability within the meaning of the ADA and applicable state or local laws, and that your disability necessitates a reasonable accommodation. If the information provided in response to this request is insufficient, the Agency may require that you see a health care professional of its choosing, at its expense. If you fail to provide the requested information or see the designated health care professional, your request for a reasonable accommodation may be denied. The Agency will keep confidential any medical information that it obtains in connection with your request for a reasonable accommodation.

After receiving your request (and medical documentation where appropriate), the Agency will engage in an interactive dialogue with you to determine the precise limitations of your disability and explore potential reasonable accommodations that could overcome those limitations. It may also be necessary to consult with your patient(s) to determine the feasibility and effectiveness of potential accommodations.

The Agency makes determinations about reasonable accommodations on a case-by-case basis considering various factors and based on an individualized assessment in each situation. The Agency strives to make determinations on reasonable accommodation requests expeditiously and will inform the individual once a determination has been made. For New York City caregivers, the Agency will make a written final determination to you identifying any accommodation that is granted or denied.



# RELIGIOUS ACCOMMODATIONS

The Agency complies with Title VII of the Civil Rights Act of 1964, and all applicable state and local fair employment practices laws and is committed to providing equal employment opportunities to all individuals, regardless of their religious beliefs and practices or lack thereof. Consistent with this commitment, the Agency will provide a reasonable accommodation of an applicant's or caregiver's sincerely held religious belief if the accommodation would resolve a conflict between the individual's religious beliefs or practices and a work requirement, unless doing so would create an undue hardship for the Agency.



If you believe you need an accommodation because of your religious beliefs or practices or lack thereof, you should request an accommodation from the Human Resources Department. You may make the request orally or in writing, but in the event of an oral request you may be asked to confirm your request in writing. Requests for accommodations should include all relevant information, such as:

**A description of the accommodation you are requesting**

**The reason you need an accommodation**

**How the accommodation will help resolve the conflict between your religious beliefs or practices or lack thereof and one or more of your work requirements**

After receiving your request, the Agency will engage in an interactive dialogue with you to explore potential accommodations that could resolve the conflict between your religious beliefs and practices and one or more of your work requirements. The Agency may ask you to provide additional information about your religious practices or beliefs and the accommodation requested. If you fail to provide the requested information, your request for an accommodation may be denied.

The Agency makes determinations about religious accommodations on a case-by-case basis considering various factors and based on an individualized assessment in each situation. The Agency strives to make determinations on religious accommodation requests expeditiously and will inform the individual once a determination has been made.

# DISCRIMINATION

## BASED ON REPRODUCTIVE HEALTH DECISION MAKING

### BROADWAY HOME CARE MAY NOT:

Discriminate or take any retaliatory personnel action against caregivers with respect to compensation, terms, conditions or privileges of employment because of, or on the basis of, the caregiver's or dependent's reproductive health decision making, including but not limited to a decision to use or access a particular drug, device or medical service; or Require caregivers to sign a waiver or other document that purports to deny caregivers the right to make their own reproductive health care decisions, including use of a particular drug, device or medical service.

Broadway Home Care also may not access the caregivers personal information regarding the caregiver's or the dependent's reproductive health decision making, including but not limited to the decision to use or access a particular drug, device or medical service without the caregiver's prior informed affirmative written consent.

Caregivers may bring a civil action in any court of competent jurisdiction against Broadway Home Care for any alleged violations of this policy. In any civil action alleging a violation of this policy, the court may: award damages, including, but not limited to, back pay, benefits and reasonable attorneys' fees and costs incurred to a prevailing plaintiff; afford injunctive relief against Broadway Home Care if it commits or proposes to commit a violation of the provisions of this policy; order reinstatement; and/ or award liquidated damages equal to 100 percent of the award for damages unless Broadway Home Care proves a good faith basis to believe that its actions in violation of this policy were in compliance with the law.

Any act of retaliation for caregivers exercising any rights granted under this policy shall subject Broadway Home Care to separate civil penalties. For the purposes of this policy, retaliation or retaliatory personnel action means discharging, suspending, demoting or otherwise penalizing caregivers for: making or threatening to make a complaint to Broadway Home Care, co-worker or to a public body, that rights guaranteed under this policy have been violated; causing to be instituted any proceeding under or related to this policy; or providing information to or testifying before any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by Broadway Home Care.

**CAREGIVERS WITH ISSUES OR CONCERNS REGARDING THIS POLICY OR WHO FEEL THEY HAVE BEEN SUBJECTED TO ANY ALLEGED VIOLATION OF THIS POLICY SHOULD CONTACT THE AGENCY.**

# PWFA

## PREGNANT WORKERS FAIRNESS ACT

An employee or applicant may request an accommodation due to pregnancy, childbirth or a related medical condition by submitting the request in writing to human resources (HR). The accommodation request should include an explanation of the pregnancy-related limitations, the accommodation needed and any alternative accommodation(s) that might be reasonable. Depending on the nature of the accommodation, the individual may be requested to submit a statement from a health care provider substantiating the need for the accommodation.

Upon receipt of a request for accommodation, HR will contact the employee or applicant to discuss the request and determine if an accommodation is reasonable and can be provided without significant difficulty or expense, i.e., undue hardship.

While the reasonableness of each accommodation request will be individually assessed, possible accommodations include allowing the individual to:

- **Sit while working.**
- **Drink water during the workday.**
- **Receive closer-in parking.**
- **Have flexible hours.**
- **Receive appropriately sized uniforms and safety apparel.**
- **Receive additional break time to use the bathroom, eat and rest.**
- **Take time off to recover from childbirth.**
- **Be excused from strenuous activities and/or activities that involve exposure to compounds deemed unsafe during pregnancy.**

An employee may request paid or unpaid leave as a reasonable accommodation under this policy; however, Broadway will not require an employee to take time off if another reasonable accommodation can be provided that will allow the employee to continue to work.

Broadway prohibits any retaliation, harassment or adverse action due to an individual's request for an accommodation under this policy or for reporting or participating in an investigation of unlawful discrimination under this policy.

# PAID PRENATAL PERSONAL LEAVE

Broadway is committed to supporting employees during pregnancy and childbirth. This policy provides eligible employees with up to 20 hours of paid prenatal personal leave for healthcare services related to pregnancy.

**LEAVE ENTITLEMENT:**

Eligible employees are entitled to up to 20 hours of paid prenatal personal leave in a 52-week period. Leave can be taken in increments of one hour. Employees are eligible upon hire and payrate for this leave will be determined based on your schedule. This will not be paid out upon separation or termination of employment.

**LEAVE SCHEDULING:**

Employees must: ⊖ Normally be scheduled to work on the day they want to take leave (this paid leave cannot be taken on a day an employee doesn't usually work). ⊖ Actively be working a case / cases with the agency to be eligible for this paid leave. ⊖ Provide reasonable notice (where possible) to your Coordinator/HR to schedule leave. ⊖ Make reasonable efforts to schedule leave around work commitments. ⊖ Coordinate with management to minimize disruptions.

# CONFLICT OF INTEREST

In order to perform their duties with honesty and fairness and in the best interest of the Agency all caregivers must avoid conflicts of interest in their employment. Conflicts of interest may arise from having a position or interest in or furnishing managerial or consultative services to any concern or business from which the Agency obtains goods or services or with which it competes or does business, from soliciting or accepting gifts, excessive entertainment or gratuities from any person or entity that does or is seeking to do business with the Agency and from using Agency property for personal or private purposes. Conflicts also may arise in other ways. If a caregiver has any doubt or any question about any of his or her proposed activities, guidance or advice should be obtained from the Director of Human Resources.

# FINANCIAL REPORTING




All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting is not only contrary to Agency policy, it may be in violation of applicable laws. Sufficient and competent evidential matter or documentation shall support all cost reports.

# PROTECTION OF ASSETS



The Agency will make available to caregivers' assets and equipment necessary to conduct Agency business including such items as computer hardware and software, billing and medical records, both hardcopy and in electronic format, fax machines, office supplies and various types of medical equipment. Caregivers should strive to use Agency assets in a prudent and effective manner. The Agency property should not be used for personal reasons or be removed from the Agency without approval from a departmental manager. A caregiver who believes that any medical equipment is not operating properly nor has an inaccurate calibration should immediately report the problem to his or her supervisor.

# ANTI-COMPETITIVE CONDUCT



The Agency will not engage in anticompetitive conduct that could produce an unreasonable restraint of trade or a substantial lessening of competition. Evaluation of anti-competitive conduct requires legal guidance. Communication by caregivers with competitors about matters that could be perceived to have the effect of lessening competition or could be considered as collusion or an attempt to fix prices should take place only after consultation with legal counsel.

# FINANCIAL INDUCEMENTS



No Caregiver shall offer any financial inducement, gift, payoff, kickback, or bribe intended to directly or indirectly induce, influence or reward favorable decisions of any government personnel or representative, any customer, contractor or vendor in a commercial transaction or any person in a position to benefit the Agency or the caregiver in any way. Caregivers are strictly prohibited from engaging in any corrupt business practice either directly or indirectly. No caregiver shall make or offer to make any payment or provide any other thing of value to another person with the understanding or intention that such payment or other thing of value is to be used for an unlawful or improper purpose. Appropriate commissions, rebates, discounts and allowances are customary and acceptable business inducements provided that they are approved by Administration and that they do not constitute illegal or unethical payments. Any such payments must be reasonable in value, competitively justified, properly documented, and made to the business entity to which the original agreement or invoice was made or issued. Such payments should not be made to individual caregivers or agents of business entities.

# ANTI-RETALIATION POLICY

No one will be subject to, and the Agency prohibits, any form of discipline, reprisal, intimidation, or retaliation for good faith reports or complaints of incidents of harassment of any kind, pursuing any discrimination claim, or cooperating in related investigations. For more information, please refer to the Anti-Retaliation Policy below.

## A. ANTI-RETALIATION STATEMENT

The Agency strictly prohibits and does not tolerate unlawful retaliation against any caregiver or other covered persons by any caregiver. All forms of unlawful retaliation are prohibited, including any form of discipline, reprisal, intimidation, or other form of retaliation for participating in any activity protected by law. Protected activities include, but are not limited to:

- **Lodging a good faith internal complaint (written or oral) opposing unlawful discrimination or harassment or complaining about violations of wage and hour law.**
- **Filing a good faith complaint of unlawful discrimination or harassment with the US Equal Employment Opportunity Commission (EEOC) or a state or local Fair Employment Practices Agency or in court.**
- **Participating in the Agency's internal investigation into allegations of sexual harassment.**
- **Supporting another caregiver's internal or administrative complaint of unlawful discrimination.**
- **Filing a good faith complaint with the US Department of Labor, state wage and hour Agency, or in court about wage and hour or pay practice concerns or participating in a wage and hour investigation or audit.**
- **Requesting an accommodation under the Americans with Disabilities Act or applicable state law.**
- **Requesting or taking leave under the Family and Medical Leave Act or applicable state law.**
- **Reporting a workplace safety concern.**

*The examples above are illustrative only, and not exhaustive.*
*No form of retaliation for any protected activity will be tolerated.*

Any caregiver, regardless of position or title, whom the Agency determines has subjected an individual to retaliation in violation of this Policy will be subject to discipline, up to and including termination of employment.

# ANTI-RETALIATION POLICY

## B. COMPLAINT PROCEDURE

If you are subjected to or observe any conduct that you believe violates this policy, you must promptly speak to, write, or otherwise contact your supervisor, the Administrator, or a Human Resources Representative. These individuals will ensure that a prompt investigation is conducted.

While you can report at any time, the Agency prefers that you submit your complaint within 30 days of the offending conduct to allow for the most effective investigation possible.

Your complaint should also be as detailed as possible, including the names of all individuals involved and any witnesses. You may be asked to confirm your complaint in writing. The Agency will investigate the facts and circumstances of all claims of perceived retaliation and will take prompt corrective action, if appropriate. All complaints will be kept confidential to the maximum extent possible and, where appropriate, the caregiver making the complaint will be advised of the final disposition of the matter.

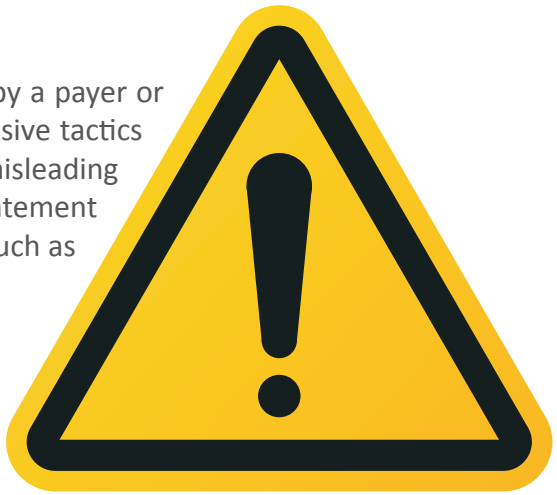
# FALSE CLAIMS PREVENTION

Broadway Home Care has a longstanding practice of fair and truthful dealing with its participants, their families, the government, health professionals and others. No individual associated with Broadway Home Care shall engage in any act of fraud, abuse or waste, such as knowingly making false statements of material fact, in the preparation or submission of any claim for reimbursement under the Medicaid program. This policy applies to all Broadway Home Care caregivers, contractors or other agents. Compliance with this Policy is a condition of employment or business relationship with Broadway Home Care. Violation of this policy is grounds for immediate termination of employment or agency relationship.

**THIS POLICY OUTLINES COMMUNITY HOME HEALTH CARE'S ANTI-FRAUD POLICY, AND THE SPECIFIC FEDERAL AND NEW YORK STATE LAWS RELATING TO FRAUD, ABUSE AND WASTE**

# FALSE CLAIMS PREVENTION

## A. DEFINITIONS OF FRAUD, ABUSE AND WASTE



Fraud is an intentional misrepresentation that, when relied on by a payer or other person, deceives that person to his or her detriment. Abusive tactics are broader than fraud and may include submitting deceptive or misleading claims to a government program like Medicaid or using a false statement to support a claim. Waste may include other deceptive tactics, such as over-utilization of otherwise necessary services.

### TYPES OF FRAUD, ABUSE, OR WASTE WHICH MAY LEAD TO LIABILITY ARE:

> Knowingly filing a false or fraudulent claim for payments to Medicaid or another governmentally funded health care program, such as billing for services not actually provided;
> Knowingly making or using a false record or statement to obtain payment on a false or fraudulent claim from Medicaid or other governmental program, such as documenting clinical care not actually provided;
> Conspiring to defraud Medicaid or other governmentally funded health care program by attempting to have a false or fraudulent claim paid; or
> Knowingly making or using, or causing to be made or used, a false record to statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government.

### EXAMPLES OF THE ABOVE INCLUDE BUT ARE NOT LIMITED TO:

- Completing timesheets for services not actually provided;
- Paying an invoice known to be false;
- Accepting or soliciting kickbacks or illegal inducements from vendors of services, or offering or paying kickbacks or illegal inducements to vendors of services;
- Paying, offering gifts, money, remuneration or free services to entice a Medicaid recipient to use Broadway Home Care services;
- Using Medicaid reimbursement to pay a personal expense;
- Embezzling; and
- Ordering and charging for medical services not necessary for the participant.

## B. MANDATORY REPORTING REQUIREMENT

If any individual subject to this policy has reason to believe that anyone associated with Broadway Home Care has engaged in any fraud, abuse or waste, the individual has a duty to report any such observations and concerns immediately to QA department. Broadway Home Care shall not retaliate against anyone submitting a timely report pursuant to this policy.

All reports shall be investigated under the supervision of QA department. All caregivers and contractors have a duty to cooperate with any investigation conducted by Broadway Home Care. Failure to show up to scheduled QA meetings are grounds for termination.

# FALSE CLAIMS PREVENTION

Broadway Home Care will take any necessary action to respond appropriately to any substantiated offense and to prevent any further offenses, including but not limited to terminating caregivers or contractors. Offenses will be evaluated for voluntary self-disclosure under applicable laws, and when warranted, they will be referred to federal and state authorities. Broadway Home Care will cooperate with government officials investigating or prosecuting any individual referred by Broadway Home Care.

## C. FEDERAL AND STATE FALSE CLAIMS ACT STATUTES

### FEDERAL FALSE CLAIMS ACT

**The Federal False Claims Act is a law that prohibits a person or entity, such as the Agency, from:**

- Knowingly presenting to a Government agency a false claim for payment or approval;
- Knowingly using a false record or statement, such as work orders and invoices for work never performed, to receive payment or approval of a false claim;
- Knowingly using a false record or statement to avoid an obligation to pay the Government;
- Knowingly conspiring to defraud the Government by getting a false claim paid; or
- Committing any other fraudulent acts detailed in the False Claims Act.

These prohibitions include claims submitted to federal health care programs like Medicare or Medicaid. The False Claims Act broadly defines the terms “knowing” and “knowingly.” Specifically, knowledge will have been proven for purposes of the False Claims Act if the person or entity: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. Reckless disregard is a term that means a conscious indifference to the consequences of one’s actions. The law specifically provides that a specific intent to defraud is not required in order to prove that the law has been violated.

A person or entity found guilty of violating the False Claims Act is required to repay all of the fraudulently obtained money. In addition, the civil penalty for filing a false claim is between $5,000 and $10,000 per false claim and the damages recoverable by the Government can be up to three times the value of the amount falsely received. In addition to being liable for damages and civil- penalties, violating the False Claims Act can subject a person or entity to exclusion from participation in federal health care programs, such as Medicare and Medicaid.

Private persons are permitted to bring civil actions for violations of the False Claims Act on behalf of the United States (also known as “qui tam” actions). If the suit is successful, the private person is entitled to receive a percentage of the recovery, depending on the level of government intervention, as well as reasonable attorneys’ fees. Persons bringing these claims (also known as “relators” or “whistleblowers”) are granted whistleblower protection under the law.



# FALSE CLAIMS PREVENTION

## PROGRAM FRAUD CIVIL REMEDIES ACT

The Program Fraud Civil Remedies Act authorizes the Department of Health and Human Services and other Government agencies to impose civil penalties upon persons making false claims or statements. The conduct prohibited by the Act is similar to that prohibited by the Federal False Claims Act. A violation of the Program Fraud Civil Remedies Act is punishable by a $5,000 civil penalty for each wrongfully filed claim, plus damages up to twice the amount of value received by the individual or entity that committed the fraud. The Act imposes liability on people or entities that file a claim that they know or have reason to know:

- Is false, fictitious, or fraudulent;
- Includes or is supported by any written statement that contains false, fictitious, or fraudulent information;
- Includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or
- Is for payment for property or services not provided as claimed.

## NEW YORK FALSE CLAIMS ACT

The New York False Claims Act is modeled after the Federal False Claims Act and operates in a very similar manner. The grounds for liability are the same in that the prohibited conduct involves intentional or reckless falsity in obtaining payment from or avoiding payment to the New York State government. The New York State Attorney General and local government bodies have the authority to investigate violations under the New York False Claims Act. The civil penalties for filing a false claim are between $6,000 and $12,000 per claim. In addition, the government (state or local) can collect damages of up to three times the amount of the value received by the individual or entity that committed the fraud.

There are also criminal penalties for intentionally making a false statement or intentionally submitting a false claim to the New York State or local government. Any person who submits false statements or deliberately conceals material information in order to receive public assistance, such as Medicaid, is guilty of a misdemeanor under the New York Social Services Law. The person may also be subject to more serious criminal penalties under the New York Penal Law depending on the severity of the fraud. Committing a fraudulent insurance act or engaging in health care fraud also may subject the person to criminal liability.

Like the Federal False Claims Act, a private person may bring a “qui tam” civil action against a person or entity on behalf of the Government. Qui tam plaintiffs are entitled to a percentage of the proceeds collected from the defendant. This percentage depends on whether or not the Attorney General or local government elects to intervene in the action. Persons bringing these claims (also known as relators or whistleblowers) are granted whistleblower protection under the law.

In addition to the New York False Claims Act, the New York Social Services Law imposes a civil penalty on a person or entity who knowingly obtains or attempts to obtain payment for items or services furnished under any Social Services program, including Medicaid, by the, use of a false statement, deliberate concealment, or other fraudulent scheme. The law gives the New York State Department of Health the authority to impose a civil penalty of no more than $2,000 per violation on any person who

# FALSE CLAIMS PREVENTION

causes Medicaid payments to be made if the person knew or had reason to know that:

- The payment involved the providing or ordering of care, services, or supplies that were medically improper, unnecessary or in excess of the documented medical needs of the person to whom they were furnished;
- The care, services, or supplies were not provided as claimed;
- The person who ordered or prescribed care, services, or supplies which were medically improper, unnecessary, or in excess of the documented medical need of the person to whom they were furnished was suspended or excluded from the medical assistance program at the time the care, services, or supplies were furnished; or
- The services or supplies for which payment was received were not, in fact, provided.

## WHISTLEBLOWER PROTECTIONS



Whistleblowing caregivers are protected from retaliation by their employers for reporting fraud, waste, and abuse. Both the Federal and New York False Claims Acts provide protection to private individuals who bring "qui tam" actions and who are later discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of the action. Federal law remedies include reinstatement with comparable seniority, back pay, interest on any back pay, and compensation for any special damages including litigation costs and reasonable attorneys' fees. New York law remedies include an injunction to restrain continued discrimination, reinstatement with comparable seniority and full fringe benefits, back pay, interest on the back pay, and compensation for any special damages including litigation costs and reasonable attorneys' fees.

# COMPLAINT FORM

NAME:_____ TODAY'S DATE: _____

COMPLAINT:

# SEXUAL HARASSMENT

The Agency is committed to maintaining a workplace free from all unlawful harassment. One form of harassment prohibited by this Policy is sexual harassment. Sexual harassment is unlawful, violates Agency policy, and will not be tolerated. The law prohibits coworkers and third parties, as well as supervisors and managers, with whom caregivers come into contact with, from engaging in harassment.

Appropriate sanctions and/or disciplinary action, up to and including termination, will be enforced against individuals engaging in sexual harassment and against supervisory and managerial personnel who knowingly allow such behavior to continue.

While this specific policy addresses sexual harassment, harassment and discrimination against persons of all protected classes is prohibited. In New York State, such classes include age, race, religious denomination, color, national origin, sexual orientation, military status, sex, disability, marital status, domestic violence victim status, gender identity and criminal history.

## A SEXUAL HARASSMENT DEFINITION

Sexual harassment is a form of sex discrimination and includes harassment on the basis of sex, sexual orientation, self-identified or perceived sex, gender expression, gender identity and the status of being transgender. Sexual harassment includes unwelcome conduct which is either of a sexual nature, or which is directed toward an individual because of that individual's sex, when:

**1. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment, even if the complaining individual is not the intended target of the sexual harassment;**

**2. Such conduct is made either explicitly or implicitly a term or condition of employment; or**

**3. Submission to or rejection of such conduct is used as the basis for employment decisions affecting an individual's employment.**

Sexual harassment known as "hostile environment" consists of words, signs, jokes, pranks, intimidation or physical violence which are of a sexual nature, or which are directed at an individual because of that individual's sex. Hostile environment harassment also consists of unwanted verbal or physical advances, sexually explicit derogatory statements or sexually discriminatory remarks made by someone in the workplace which are offensive or objectionable to the recipient, which cause the recipient discomfort or humiliation, or which interfere with the recipient's job performance.

Sexual harassment known as "quid pro quo" harassment occurs when a person in authority tries to trade job benefits for sexual favors. This can include hiring, promotion, continued employment or any other term, condition or privilege of employment.

Sexual harassment can occur between males and females, or between persons of the same sex. Sexual harassment that occurs because the target is transgender is also unlawful.

# SEXUAL HARASSMENT

## B SEXUAL HARASSMENT EXAMPLES

The following describes some of the types of acts that may be unlawful sexual harassment:

- Physical acts of a sexual nature, like:
  - → Touching, pinching, patting, kissing, hugging, grabbing, brushing against another caregiver's body or poking another caregiver's body;
  - → Rape, sexual battery, molestation or attempts to commit these acts.
- Unwanted sexual advances, propositions, or other sexual comments, such as:
  - → Requests for sexual favors accompanied by implied or overt threats concerning the target's job performance evaluation, a promotion or other job benefits or detriments;
  - → Subtle or obvious pressure for unwelcome sexual activities;
  - → Sexually oriented gestures, noises, remarks, jokes or comments about a person's sexuality or sexual experience, which are sufficiently severe or pervasive to create a hostile work environment.
- Sexual or discriminatory displays or publications anywhere in the workplace, such as:
  - → Displaying pictures, posters, calendars, graffiti, objects, promotional material, reading materials or other materials that are sexually demeaning or pornographic. This includes such sexual displays on workplace computers or cell phones and sharing such displays while in the workplace.
- Hostile actions taken against an individual because of that individual's sex, sexual orientation, gender identity or status of being transgender, such as:
  - → Interfering with, destroying or damaging a person's workstation, tools or equipment, or otherwise interfering with the individual's ability to perform the job;
  - → Sabotaging an individual's work;
  - → Bullying, yelling, name-calling;
  - → Sex stereotyping – When conduct or personality traits are considered inappropriate simply because they may not conform to other people's ideas or perceptions about how individuals of a particular sex should act or look.

The Agency's policy also applies to harassment based on race, color, religion, national origin, ancestry, ethnicity, creed, age, disability, citizenship, veteran and military status, marital status, domestic violence victim status, genetic information, or any other characteristic protected by law. Such harassment often takes a similar form to sexual harassment and includes harassment that is:

- **VERBAL** (e.g. epithets, derogatory statements, slurs, derogatory comments or jokes, or obscene language)
- **PHYSICAL** (e.g. assault or inappropriate physical contact)
- **VISUAL** (e.g. displaying derogatory posters, cartoons, drawings or making derogatory gestures)
- **ONLINE** (e.g. derogatory statements in an e-mail or through any social media platform)

**THIS LIST IS ILLUSTRATIVE ONLY, AND NOT EXHAUSTIVE. NO FORM OF HARASSMENT WILL BE TOLERATED.**

# SEXUAL HARASSMENT

## C COMPLAINT AND INVESTIGATION PROCEDURE



Preventing sexual harassment is everyone's responsibility. The Agency cannot prevent or remedy harassment unless it knows about it. Anyone who witnesses, becomes aware of, or is subjected to behavior that may constitute harassment or otherwise violates this Policy is strongly encouraged to **immediately** report such behavior to their Coordinator. If an individual is not comfortable reporting to their Coordinator, they should then report it to Human Resources.

Reports of harassment or any other violation of this policy should be made in writing, though verbal reports will be accepted. A Complaint Form for the submission of reports of unlawful harassment or any other violation of this policy may be found in this handbook. Any report should be as detailed as possible and include the names of all individuals involved, a description of the incident(s) complained of, the names of all witnesses, and any documentation or other evidence that supports the allegations. If the report is verbal, the complainant will be asked to complete a written Complaint Form. If he or she declines, the Agency may prepare a Complaint Form based on the verbal report.

All supervisors and managers who receive a report or information about, observe, or suspect any potential harassment or other violation of this Policy **must immediately** report it to Human Resources. A supervisor or manager who fails to make such a report or otherwise knowingly allows harassing or retaliatory behavior to continue will be subject to disciplinary action, up to and including termination of employment.

The Agency will conduct an investigation of any report or complaint of harassment or any other violation of this Policy that it receives. Investigations will be conducted in a prompt, thorough, and timely manner, and will be confidential to the extent possible. The Agency will take prompt and appropriate corrective action whenever it determines that violation of this Policy has occurred.

All persons involved in the Agency's investigation will be accorded due process, as outlined below. While the process may vary from case to case depending on the circumstances, an investigation of a report of harassment or other violation of this Policy will generally include the following steps:

- **Upon receipt of a report of harassment or other violation of this Policy, the Agency will conduct an immediate review of the allegations and take any appropriate interim action**
- **Relevant information will be collected**
- **Interview the complainant, witnesses, and the accused**
- **Where appropriate, depending on the facts of each case, notify appropriate and/or involved parties about the investigation, its outcome, and/or relevant information**
- **Implement any remedial measures.**

Caregivers are required to participate and answer truthfully any questions posed in an investigation by the Agency.

# SEXUAL HARASSMENT

## D RETALIATION PROHIBITED

The Agency strictly prohibits and does not tolerate any retaliation against an individual because he or she has in good faith made a complaint of harassment or testified or assisted in a legal proceeding. Any caregiver who believes that he or she has been subjected to retaliation must immediately make a report to Human Resources.

## E REDRESS RIGHTS & ADJUDICATION FORUMS FOR SEXUAL HARASSMENT

Sexual harassment is misconduct and will be grounds for discipline, including termination. Sex harassment is unlawful under the New York Human Rights Law, the New York City Human Rights Law, and the federal Civil Rights Act of 1964, Title VII. In addition, there may be applicable local laws that prohibit harassment and sex discrimination.

A complaint alleging a violation of the Human Rights Law may be filed with either the Division of Human Rights (DHR) or in New York State Supreme Court. DHR's main office contact information is: NYS Division of Human Rights, One Fordham Plaza, Fourth Floor, Bronx, New York 10458. You may call **(718) 741-8400** or visit: **www.dhr.ny.gov**. Call **(800) HARASS-3** (1-800-427-2773) or visit **www.dhr.ny.gov/complaint** for more info. A complaint alleging a violation of Title VII may be filed with the Equal Employment Opportunity Commission (EEOC) within three hundred days of the alleged harassment. Contact the **EEOC** by calling **(800) 669-4000** (TTY: (800) 669-6820), visiting their website at **www.eeoc.gov** or via e-mail at **info@eeoc.gov** if you wish to file a complaint with the EEOC. Caregivers who work in New York City may file a complaint of sexual harassment with the New York City Commission of Human Rights (**CHR**), at 40 Rector Street, 10th Floor, New York, New York, by calling **311** or **(212) 306-7450** or visiting **www.nyc.gov/html/cchr/html/home/home.shtml**.



The remedies available to victims of sexual harassment vary depending on the circumstances and the forum involved, but may include requiring the defendant(s) to take action to stop the harassment, or redress the damage caused, including reinstatement/instatement to a job, payment of monetary damages (e.g. back pay, out-of-pocket expenses), compensatory damages, punitive damages in certain circumstances, reasonable attorneys' fees, and civil fines.

If the sexual harassment involves unwanted physical touching, coerced physical confinement or coerced sex acts, the conduct may constitute a crime. Redress can be sought by contacting the local police department.

# SEXUAL HARASSMENT COMPLAINT FORM

If you believe that you have been subject to unlawful harassment or retaliation, you are strongly encouraged to complete this form and submit it to Human Resources. Please complete all aspects of this form in as much detail as possible. In particular, you are encouraged to include your name and contact information, as anonymous complaints may be very difficult to investigate.

The Agency prohibits retaliation of any kind against an individual for making a complaint in good faith. *Please use additional sheets of paper if necessary.*

Your Name: _____ Your Phone Number: _____

Your Title/Position: _____ Your Coordinator's Name: _____

**COMPLAINT INFORMATION**

**1.** Name and title of any alleged harasser or retaliator:

Name: _____ Title: _____

**2.** Details of the harassment or retaliation. Please include as much detail as possible, including what happened, how it is affecting you and your work, and your reasons for believing that the conduct is sexual or other harassment or retaliation.

_____

_____

_____

_____

**3.** Date(s) of harassment or retaliation: _____

**4.** Please list the names and contact information of each witness or individual who may have information related to your complaint:

_____

_____

**5.** Identify any documents or other evidence that you believe substantiates your complaint of harassment or retaliation. Attach any relevant documents and evidence.

_____

*I certify that I have read (or have had read to me) the foregoing complaint and know the contents of this complaint; and that the foregoing is true and correct, based on my current knowledge, information, and belief.*

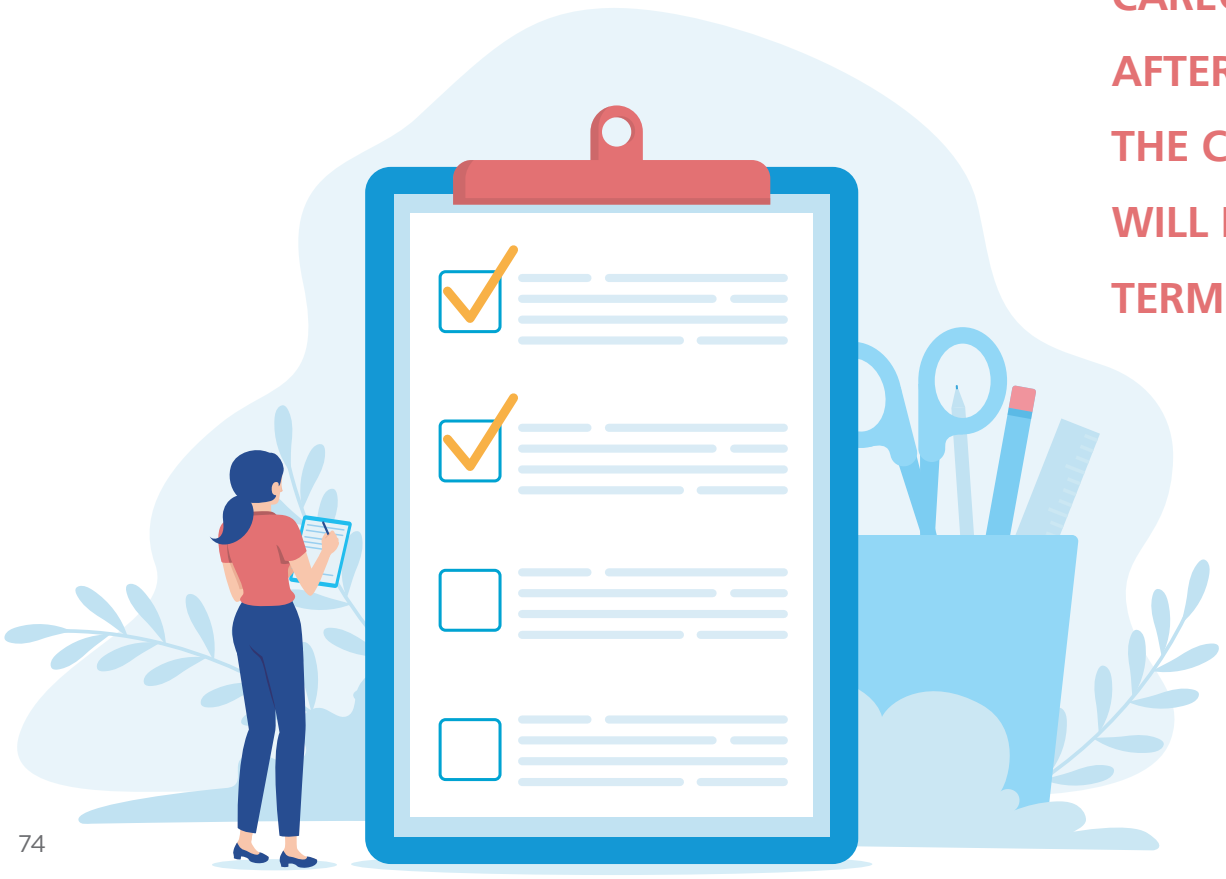
Signature: _____ Date: _____

# YEARLY COMPLIANCE REQUIREMENTS

Below is a list of annual compliance requirements that must be met by each caregiver as a condition of them continuing to work a case. If the requirements expire and are not renewed, the caregiver is not authorized to service the case. To be clear, service rendered on the first day that the caregiver is out of compliance with any of the below requirements will not be paid. Caregivers should not report to work on the first day that they are out of compliance with these requirements.

It is the caregiver's obligation to make sure their credentials are updated and in compliance with the law before they render any services. The Agency will make every attempt to contact a caregiver on the phone number and email address provided to obtain updated compliance paperwork before the date that the compliance paperwork is scheduled to expire. But if a caregiver fails to hand in updated compliance paperwork on time, the Agency will consider it as a voluntary resignation and/or the caregiver will not be allowed to work the case until the paperwork is updated and is in compliance with all requirements.

**IF A CAREGIVER FAILS TO STAY IN COMPLIANCE THE CAREGIVER MAY REMAIN ON INACTIVE STATUS FOR 14 DAYS WHILE HR ATTEMPTS TO FOLLOW UP WITH THE CAREGIVER. AFTER 14 DAYS, THE CAREGIVER WILL BE TERMINATED.**



# IN-SERVICE

*In-service is completed yearly according to DOH regulations. Twelve (12) hours of in-service education is required each year for Home Health Aides and six (6) hours is required each year for Personal Care Aides. In-service is completed online. Upon hire, you will be assigned a username (usually your email) and password. If you do not know what your username is, feel free to call HR for assistance*

*You are not allowed to do any work in addition to the 6 or 12 hours of in-service. This means that any work related to the in-service must be completed within the 6 or 12-hour sitting. You cannot complete tests or similar written assignments beyond the 6 or 12-hour sitting. Should there be extenuating circumstances and you are required to spend more than 6 or 12 hours in the in-service, you need to let your designated HR representative know.*

*All caregivers must complete the yearly in-services in order to stay in compliance with the Agency's Policies and Procedures.* FAILURE TO COMPLY WILL RESULT IN AN IN-ACTIVE STATUS, AND YOU WILL BE REPLACED ON YOUR CASE. IF YOU HAVE SKIPPED ANY OF THE IN-SERVICE HOURS BY END OF A CALENDAR YEAR YOUR STATUS WITH THE AGENCY MAY LEAD TO TERMINATION AS THE COMPLETED HOURS FOR IN-SERVICE DO NOT CALCULATE AS HOURS SERVICING A PATIENT, YOU WILL HAVE TO REAPPLY AFTER 6 MONTHS WITH THE AGENCY AS A NEW HIRE.

*In-service payment will be issued upon completion.*



# PHYSICALS



Each caregiver must have a physical examination within the past year by a physician prior to the beginning of the patient contact. Physical Examinations must include evidence of freedom from condition, which may prove hazardous to you or your patient's health. A yearly assessment is required for all caregivers. Our agency will call you to complete the assessment.

# TB SCREENING



**TB SCREEN** A yearly assessment is required for all caregivers.
Our agency will call you to complete the assessment.

## What is TB?

- Anyone can get TB
- TB spreads through the air when someone with TB disease coughs, sneezes, speaks or sings
- Tuberculosis (TB) is a disease caused by bacteria called Mycobacterium tuberculosis*
- The bacteria usually attack the lungs . But TB bacteria can attack any part of the body such as the kidney, spine, and brain
- If not treated properly, TB disease can be fatal
- Good news, people with TB disease can be treated when they seek medical help.
  Most people with latent TB infection can take medicine so that they will not develop TB disease
- An estimated 60 million lives were saved worldwide through TB diagnosis and treatment between 2000 and 2019

## Risk Factors for TB disease

- Coming from an area of high infection, where you stayed more than 30 days
- Everywhere EXCEPT: Australia, Canada, New Zealand, the United States, England/UK, the Republic of Ireland, Belgium, the Netherlands, Luxembourg, France, Germany, Denmark, Norway, Sweden, and Iceland. Finland, Southern Germany, Switzerland, and Austria)
- Exposure to someone with active TB
- Diagnosis of latent TB




## TB signs and symptoms

- Productive cough for more than 3 weeks
- Coughing up blood
- Unexplained weight loss
- Fever, chills, or drenching night sweats for no known reason
- Persistent shortness of breath
- Unexplained fatigue for more than 3 weeks
- Chest pain

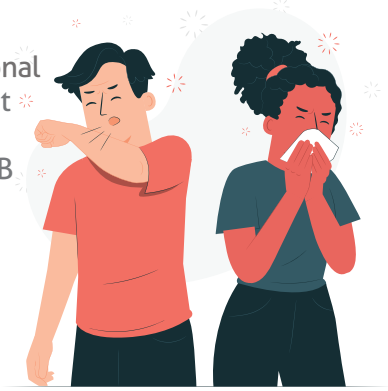
# TB SCREENING

## TB Disease and Latent TB

- TB disease is an active infection and must be treated
- Requires treatment (6-9 months)
- Requires quarantine for some period
- Latent TB Infection means you had or were exposed to TB in the past but are not currently infectious
- Latent TB can become active TB disease
- Treating Latent TB prevents it from becoming an active infection
- Can be treated in as little as 3-4 months with no requirement to quarantine

## Healthcare Worker Requirements

- Follow your agencies policies and procedures regarding TB testing and screening
- Test and screen prior to starting a new job
- Screen annually
- May require additional testing or treatment if you are at risk or have Latent TB or TB disease





# INFLUENZA

The Agency requires all caregivers to have documented influenza vaccination status on file each year and require unvaccinated personnel to wear a surgical mask while in areas where patients or residents may be present during periods that the Commissioner of Health determines that the influenza season is underway.

# ON-SITE PERFORMANCE EVALUATIONS

Performance reviews are an ongoing communication between caregivers and supervisors to provide a clear understanding of what is expected in the job. A performance review provides an opportunity for caregivers to communicate any concerns they may have about their job or their future. Aides are expected to have a working knowledge of permissible activities involved in their work. If there is a question regarding an activity that may be beyond the scope of employment, please call your Coordinator for help.



# ANNUAL HR REVIEW

Caregivers' performance will be reviewed at least once annually, on or around their anniversary date. Other periodic reviews may be scheduled as an ongoing form of communication between caregivers and supervisors.

# WAGE AND PAYROLL

The Agency and you are required to keep accurate records of time worked in order to calculate caregivers' pay. You will be paid on a weekly basis.

The week starts on Saturday 12am and ends on Friday 11:59pm. Timesheets should be filled out accordingly and hours should be accounted for based on a Saturday to Friday week schedule.

As a general matter, caregivers are only permitted to work those hours that were authorized for the patient to receive care from the Agency. Of course, the Agency understands that exceptions and circumstances beyond the caregivers' control will arise from time to time. For example, if a caregiver is required to stay longer than their scheduled shift because the relief caregiver has not arrived, the caregiver will be paid for the additional time that he/she renders services to the patient. However, caregivers can never approve additional hours for themselves, and patients cannot extend caregivers' hours of work. The Coordinator should be immediately contacted before the caregivers undertakes performing any additional work beyond your scheduled shift time.

Unless otherwise instructed, staff is not permitted to work or provide services to patients while the patient is admitted into a hospital.

As noted above, depending on the patient's needs, a caregiver may need to wait for replacement staff before you can leave at the end of your shift. If the replacement staff is more than 15 minutes late, the caregiver should call the office. The Agency will make every effort to locate the replacement staff and call the caregiver back with an explanation and/or substitute. Caregivers are required to remain with the patient until arrangements can be made to meet the patient's needs.



You are not permitted to work anywhere else at the same time you are working for your patient. You may not work for the patient more than the allotted hours as set forth by the Coordinator.

# WAGES/OVERTIME

Your hourly rate shall be initially determined at the time of employment. You will be notified at the time of hire of your basis of pay (salary, hourly) and your pay rate. Salaries and/or wages may be changed from time to time at the Agency's determination.

In addition, caregivers will receive, for all Wage Parity cases, a Wage Parity benefit and/or cash in lieu of a benefit for the first 40 hours of work. Any work performed beyond 40 hours in a workweek will be paid at one and one-half times the regular rate of pay. Wage Parity will not be paid for hours worked above 40 per week. The Agency will also comply with any applicable local living wage and wage parity laws.

If you have any questions regarding your compensation, please contact your Human Resources Representative.

Non-exempt caregivers will receive overtime pay in accordance with applicable federal and state law at a rate of one and one-half times their regular rate of pay for all hours worked over 40 hours in any workweek. Overtime pay is based on hours actually worked. Any overtime work must be approved by your Coordinator before the overtime hours are worked. Failure to comply with this requirement may subject you to discipline.

Overtime will be paid based on the caregivers' "regular rate of pay." The regular rate of pay may vary from week to week if the caregiver works jobs that have different or multiple rates of pay. If you ever have questions about how your overtime rate was computed, please contact the agency.

# PAYROLL ERROR/MEAL PERIOD

You should review your payroll checks for errors. If you believe there are errors in your pay, including that you have been overpaid or underpaid, that improper deductions have been taken from your pay, or that your pay does not accurately reflect all hours worked, including overtime, you must report your concerns to the Human Resources Representative immediately. The Agency will promptly investigate all reported complaints and, if appropriate, take corrective action.

The Agency prohibits and will not tolerate retaliation against any caregiver because that caregiver filed a good faith complaint under this policy. Specifically, no one will be denied employment, promotion or any other benefit of employment or be subjected to any adverse employment action based on that person's good faith complaint. In addition, no one will be disciplined, intimidated or otherwise retaliated against because that person exercised rights under this policy or applicable law.

If you work for more than 6 consecutive hours, you are entitled to a meal period during your shift. However, the nature of home care necessitates that only one caregiver be on duty at any given time. Thus, it is customary for caregivers to eat on the job without being relieved as they cannot abandon the patient. Given the requirements that a caregiver remain with the patient, you voluntarily consent to taking your meal period without being fully relieved of your duties and you understand and agree that this means that your meal period may be interrupted by a call to duty. However, your meal period will be paid.

If you do not want to voluntarily consent to this arrangement, and instead desire a meal period completely relieved from duties, you must submit a written request to the Coordinator. In that case, the Agency may remove you from the case to which you are assigned and undertake reasonable efforts to find a replacement case that allows you to take such meal periods. Such meal periods may be unpaid as permitted by applicable law.

# USE OF E.A.V.S.

## ELECTRONIC ATTENDANCE VERIFICATION SYSTEM

Broadway Home Care requires the use of an EAVS when working with a patient. You are required to use the EAVS system when you report to work for the patient, and when you have completed your shift. Clock in and out must be done from the patient's home phone or through the designated mobile app. On those occasions when calling from the patient's home phone is not possible, and the mobile app is not available to you, it must be discussed with your Coordinator.




On your ID badge, you will be provided with a designated ID number to use for clocking in. It is prohibited to allow anyone else to use your ID number. You must clock in and out for each shift that is worked. Failure to use the call-in system properly may cause a delay in your pay.

A clock in/out is IN ADDITION to timesheets. A clock in does not replace the need to submit a timesheet.

PHONE NUMBERS TO CLOCK IN:

Toll-Free **855-343-7978**

English **844-597-5175**

Spanish **914-401-0025**

French/Creole **845-531-5990**

Russian **845-678-8394**

## CALL IN

1. Dial the number
2. Press 1 for CALL IN
3. Enter your Assignment ID
4. The system will repeat the assignment you entered Press 1 to confirm or 0 to re- enter & call is complete

## CALL OUT

1. Dial the number
2. Press 2 for CALL OUT
3. Enter your assignment ID
4. The system repeats the assignment you entered. Press 1 to confirm or 0 to re-enter & call is complete
5. Enter all the duty IDs that you did for the patient. This can be found on the patient's plan of care (small 3-digit number)
6. Press 000 to complete the call

# RULES OF E.A.V.S.

## ELECTRONIC ATTENDANCE VERIFICATION SYSTEM

RULES

- Call in/Call out: can only be done from the patient's HOME PHONE. Calling in from personal cell phone will not be allowed.
- A call out for a shift without a call in will *NOT* be accepted.
- LIVE-IN: when working on a live-in case, you should call in regularly when you are on to the case. This can vary based on each case. For example, if you clock in at 8am, please make sure to clock out at 8am the next day and clock back in if you are still with client.
- SHABBAT OBSERVANT: Notify the Agency if the patient is Shabbat observant and therefore you cannot use the patient's phone.
- NO DIRECT PHONE NUMBER: Patients may not always have a direct phone number. In such a case notify the Agency of the situation.
- ROTARY PHONE: The time attendance system will not work on a rotary phone.
- Payroll is generated through the call in and call out system as well as the EVV system through the HHAx app.
- If you are experiencing problems with calling in or calling out, please notify the Agency immediately.
- Clocking in and out through the phone system or HHAx app is a NYS requirement. Please contact your coordinator with any issues you may have clocking in and out so that it can be fixed.

# USE OF MOBILE APP

*Broadway Home Care now has a mobile app to make the process of clocking in and out easier for you.*

## SETUP GUIDE

Download on the App Store

GET IT ON Google play

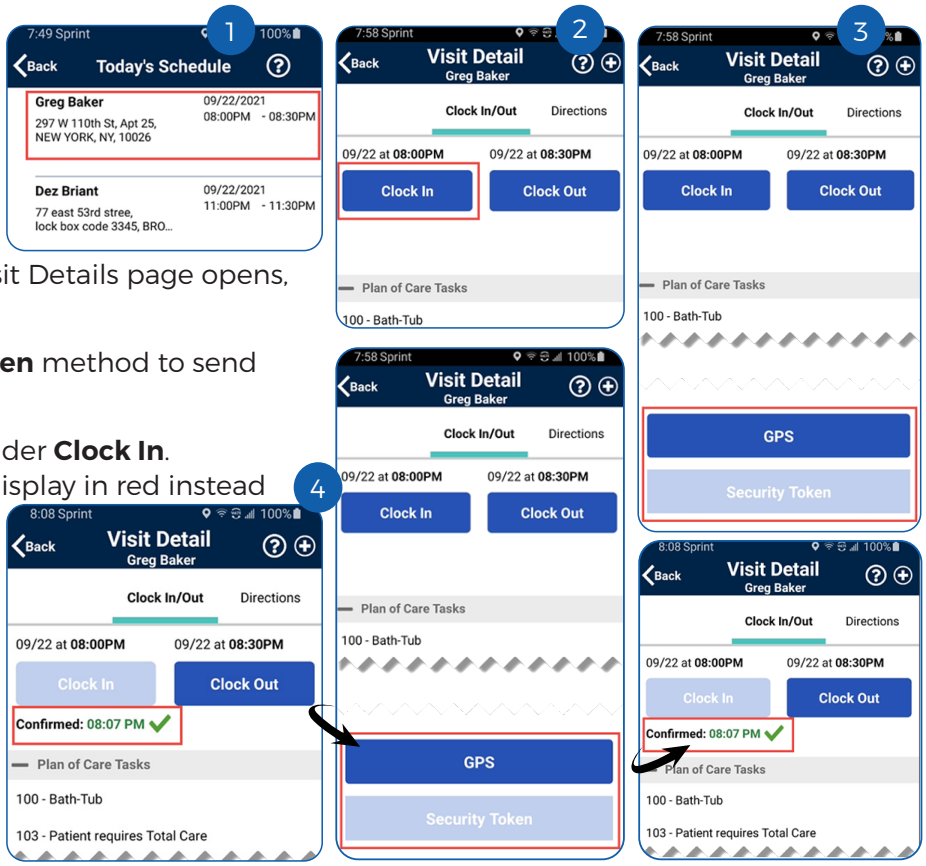
The HHA Mobile App is free to use and is available to download on iTunes and Google Play stores. Caregivers are responsible for downloading and installing the app. Once downloaded, caregivers should call the Agency with their credentials to finalize the app set up.

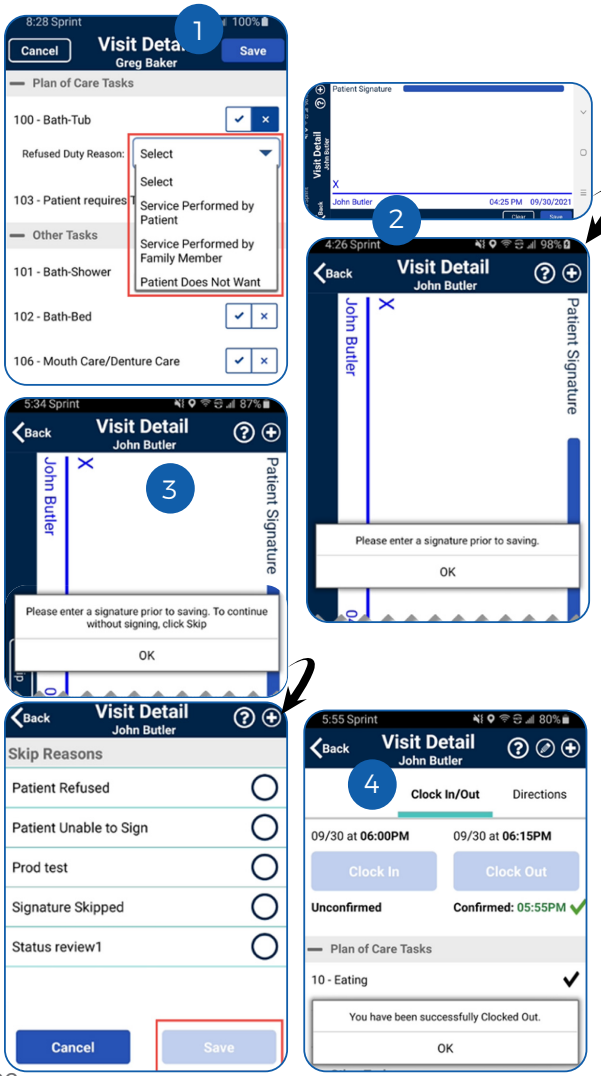
# HHA EXCHANGE

## EVV CLOCKING IN/OUT PROCESS

### Complete the following steps to clock in for a visit:

1. From the Main screen, tap **Today's Schedule**. Select the visit. In this example, Greg Baker.
2. When the **Clock-In/Out** tab of the Visit Details page opens, tap **Clock In**.
3. Select either the **GPS** or **Security Token** method to send an EVV.
4. A successful EVV displays in green under **Clock In**. Unsuccessful EVV placement times display in red instead of green.



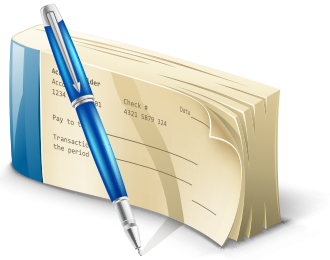

### Complete the following steps to clock out for a visit:

1. When the visit is completed, tap Clock Out on the Clock In/Out page. You are prompted to select the duties performed. Duties MUST be entered as per the patient's plan of care.
   • Select the checkmark for duties performed.
   When servicing mutual patients, you must enter separate POC duties for each patient.
2. If the visit requires a patient signature, obtain the signature on the device to process the visit.
   The Patient Signature may be required during clock in and/or clock out depending on the contract authorizing the visit. This feature is configured by the agency.
3. If the agency allows you to skip the Patient Signature, you are prompted to tap Skip and select the reason why the patient cannot sign.
   The Save button is unavailable until a reason is selected.
4. Tap Save when the required screens are completed to return to the Visit Details page with a confirmation message. Tap OK to return to the home screen.

# COMPENSATION

Payroll checks will be mailed out to your home weekly on Thursday. You can also choose to receive your pay via direct deposit. Broadway Home Care highly recommends you choose the direct deposit benefit to avoid disruptions in check distribution due to weather or failed delivery methods.

If you wish to receive direct deposit, please submit the direct deposit form found on the next page. Once signed up, your pay will be in your bank account Friday morning at 6am (this may vary depending on your bank). Your paystubs will be available to view online. If you want your paystubs mailed to you, please call in to request them.



If you are working for an eligible patient, you will receive Wage Parity benefits in addition to your pay. Below you will find more detailed information on our Wage Parity Program.

# WAGE PARITY



Caregivers who work on cases that are **reimbursed by Medicaid** in whole or in part and in certain regions of the State are eligible to receive **"wage parity" benefits in addition to minimum wage.** The wage parity amounts vary from region to region and year to year. Information about wage parity will be distributed during orientation or can be requested from the Human Resources Representative.

# DIRECT DEPOSIT FORM

Broadway Home Care offers direct deposit to all our caregiver. This option, if you decide to choose it, allows Broadway Home Care to deposit your weekly pay into your own personal savings or checking accounts. Instead of receiving a check every week, your money will be available to you every Friday morning. All who choose DIRECT DEPOSIT will have their paystubs available online to view and print. Paystubs will not be mailed.

If you still wish to receive your weekly pay stub in the mail from us, in the form of a non-negotiable check that cannot be cashed, please check the box below. If no box is on this form is checked, your paystubs will be accessible online and will not be mailed. If you receive the weekly pay stub in the mail it will not be available online.

# DIRECT DEPOSIT

**SCAN HERE**
**FOR DIRECT DEPOSIT FORM**

FILL IN THEIR ACCOUNT INFO BELOW AND RETURN THIS PAGE TO YOUR LOCAL BROADWAY HOME CARE OFFICE if you would ike to participate in the direct deposit option ALONG WITH EITHER A BLANK VOIDED CHECK OR A SAVINGS DEPOSIT SLIP or BOTH if splitting deposit.

**YOU CANNOT HAVE DIRECT DEPOSIT AND RECEIVE A PAY CHECK.**

PLEASE PRINT ALL INFORMATION BELOW

Direct Deposit Request *(Don't forget to staple your voided check or filled in deposit slip for savings).*
I authorize my employer/payer to initiate electronic credit entries and, if necessary, debit entries and adjustments for any credit entries made in error, to my financial institution listed below:

FIRST NAME: _____ LAST NAME: _____ SS#: _____

HOME ADDRESS: _____ APT#: _____

CITY: _____ STATE: _____ ZIP CODE: _____

BANK NAME: _____

BANK ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

ROUTING #: _____ CHECKING ACCT #: _____ DEPOSIT %: _____

ROUTING #: _____ SAVINGS ACCT #: _____ DEPOSIT %: _____

☐ I agree to have my paystubs available online

☐ I wish to receive my weekly pay stub by mail. I am aware the paystubs will not be available to view and print online

CAREGIVER SIGNATURE: _____ DATE: _____

# BENEFITS

A COMPREHENSIVE BENEFITS PAMPHLET IS AVAILABLE IN ALL OF OUR SATELLITE OFFICES, AND IT WILL BE PROVIDED TO YOU FOR REVIEW DURING ORIENTATION. YOU MANY ALSO REQUEST FROM YOUR HR REPRESENTATIVE TO HAVE A PAMPHLET MAILED TO YOU. THIS SECTION GENERALLY DESCRIBES SOME OF THE BENEFITS WE PROVIDE TO ALL CAREGIVERS. BECAUSE THE TERMS AND CONDITIONS OF VARIOUS PLANS CHANGE OVER TIME, A SUMMARY OF THE BENEFITS BEING OFFERED BY THE AGENCY WILL BE GIVEN AT ORIENTATION.

## HOLIDAY PAY

The following days are considered holidays and you will be given an additional $1.00 per hour if you work these days:

- New Year's Day
- July 4th
- Thanksgiving Day
- Christmas Day

## WORKER'S COMPENSATION

If you are injured while on the job, you may be covered for the medical expenses you incur for the work-related injury and salary lost during the period that you are disabled



from working. All caregivers are required to report injuries prior to leaving their assignment. Caregivers may forfeit any right to care by not promptly reporting to this agency.

## DISABILITY INSURANCE

You are entitled to New York State Disability benefits if you have a non-job-related illness and are unable to work for more than seven (7) days and are receiving medical care. If you are ill or require hospitalization, notify the office immediately. New York State Disability will pay up to 50% of you average/weekly salary, after the first seven (7) days of illness, and for up to 26 weeks. Caregivers on disability leave are still required to notify their Coordinator of their status and periodically check in with the Agency. Information about your condition and circumstances may be required before you are reinstated to work.

## MEDICAL INSURANCE

Eligible caregivers may enroll in a single, a single plus one dependent, or a family contract health insurance plan offered by the Agency. Eligibility will be defined



by the specific insurance contract in effect. Information and enrollment forms may be obtained from Human Resources.

# TIME, ATTENDANCE AND TIME OFF

All personnel are expected to show up at their assignments on time, with proper identification and dressed appropriately.




It is your responsibility to arrive at your assignment promptly at the start of the shift. If you are unable to cover your case for any reason, you must notify the Agency as early as possible so that we can arrange for coverage. Do not call out or make any schedule changes with the patient directly.

You can call our office at any time, 24 hours, and 7 days a week.
Office hours are from 9:00am to 5:00pm Monday through Thursday; Friday 9:00 a.m. to 1:00 p.m. In addition, the Agency's supervisor is on-call whenever the office is closed and can be reached by calling the regular office number. Please note, if you reach a voicemail box you should call again to reach the operator.

**Emergencies come up, however, as essential healthcare workers, caregivers have a responsibility to the patients and the Company if they should need to take a day off unexpectedly. Caregivers are required to provide at least 24-hours notice of an unexpected absence from work. Medical emergencies will not be subject to this standard, nor will any call-offs that are permitted to be provided with a shorter notice under any federal, state or local law. However, in all other circumstances, caregivers must provide the requisite 24-hour notice of a cancelled shift so that the Company has adequate time to secure a replacement caregiver for a patient. Caregivers who fail to follow these standards endanger the welfare of our patients and will be disciplined for violations of this policy.**

Failure to notify the Agency that you will be out sick, late, on vacation, etc. may be grounds to terminate your employment. While we understand that situations arise which may stop or delay you from working on a particular day, it is extremely important that such information be known to the Agency.

# FAMILY AND MEDICAL LEAVE

The Company provides leave according to the Family and Medical Leave Act of 1993 (FMLA) and the New York Paid Family Leave (NYPFL) Law to covered caregivers in certain circumstances and as more fully described in this policy.

## ELIGIBILITY

To qualify for FMLA leave, you must: (1) have worked for the Company for at least 12 months; (2) have worked at least 1,250 hours in the last 12 months; and (3) be employed at a work site where the Company has 50 or more caregivers within 75 miles. If you have any questions about your eligibility for FMLA leave, please contact the Human Resources Department.

To qualify for NYPFL, a New York caregiver whose regular schedule is 20 or more hours per week must have worked for the Company for at least 26 consecutive weeks preceding the first full day leave begins. A New York caregiver whose regular schedule is less than 20 hours per week must have worked in the Company's employment for 175 days (which does not have to be consecutive) to qualify for NYPFL. If you have any questions about your eligibility for NYPFL, please contact the Human Resources Department.

## LEAVE ENTITLEMENT

FMLA. You may take up to **12 weeks of unpaid FMLA** leave in a 12-month period, which is measured using a "rolling" method that is measured backward from the date you use any FMLA leave, for any of the following reasons:

1. The birth of a son or daughter and in order to care for such son or daughter (leave to be completed within one year of the child's birth)
2. The placement of a son or daughter with you for adoption or foster care and in order to care for the newly placed son or daughter (leave to be completed within one year of the child's placement)
3. To care for a spouse, son, daughter, or parent with a serious health condition
4. For your own serious health condition which renders you unable to perform any of the essential functions of your position
5. A qualifying exigency of a spouse, son, daughter, or parent who is a military member on covered active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty)

You may take **up to 26 weeks** of unpaid FMLA leave in a single 12-month period, beginning on the first day that you take FMLA leave to care for a spouse, son, daughter, or next of kin who is a Covered Service member and who has a serious injury or illness related to active duty service, as defined by the FMLA's regulations (see Definitions section, Military Caregiver Leave subsection below).

# NYPFL

The 52 consecutive week period is measured using a "rolling" method that is measured backward from the date you use any NYPFL. NYPFL may be taken for the following reasons:

**1.** To care for a spouse, domestic partner, child, parent (including in-laws), grandparent, or grandchild with serious health condition;

**2.** To bond with a child during the first 12 months after the child's birth or placement for adoption or foster care or to meet adoption or foster care obligations (leave to be completed within one year of the child's birth or placement); or

**3.** To meet qualifying exigencies arising from the fact that your spouse, domestic partner, child, or parent is on active duty or "has been notified of an impending call to active duty" in the U.S. Armed Forces.

Note that NYPFL is not available for the caregiver's own serious health condition.

During NYPFL, paid benefits will be provided by the Company's NYPFL insurance carrier, at the following level provided by law: **67% of the caregiver's AWW, up to 67% of the NYS AWW**

The NYS Average Weekly Wage is the average weekly wage paid across New York State during the previous calendar year and is determined and published by the New York State Department of Labor each year.

Pay under NYPFL is available from the first day of the leave (no waiting period). The insurance carrier, not the Company, is responsible for approving and paying benefits under the NYPFL Law. To receive such benefits, you will be required to file a claim with the carrier and to follow the carrier's requirements with respect to claim filing, certification, and supporting documentation (see NYPFL Claim and Certification Procedure section below).

**If you are eligible for leave under both the FMLA and the NYPFL, your leave under both of these laws will run concurrently to the maximum extent permitted by law.**

# FAMILY MEMBERS WORKING FOR THE COMPANY

**FMLA.** Where eligible spouses both work for the Company, they will be limited to a combined total of 12 weeks of FMLA leave in a 12-month period for the birth/placement of and bonding with a child and the care of a parent with a serious health condition. The spouses will also be limited to a combined total of 26 weeks of FMLA leave in a 12-month period to care for a Covered Service member with a serious injury or illness (see Definitions section, Military Caregiver Leave subsection below).



**NYPFL.** The Company will not permit more than one caregiver to take NYPFL at the same time to care for the same family member (e.g., where both spouses or other qualifying relatives work for the Company).

# DEFINITIONS

SERIOUS HEALTH CONDITION – FMLA. For FMLA purposes, "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves: (a) inpatient care; or (b) continuing treatment by a health care provider."

Inpatient care means an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, as defined by the law, or any subsequent treatment in connection with such inpatient care. A serious health condition involving continuing treatment by a health care provider requires any one or more of the following:

A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves: (a) treatment two or more times, within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, a nurse under direct supervision of a health care provider, or a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or (b) treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider;

Any period of incapacity due to pregnancy or for prenatal care;

Any period of incapacity or treatment for such incapacity due to a chronic serious health condition;

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective; and

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or a provider of health care services under orders of, or on referral by, a health care provider.

SERIOUS HEALTH CONDITION – NYPFL. For NYPFL purposes, "serious health condition" means illness, injury, impairment, or physical or mental condition that involves: (a) inpatient care in a hospital, hospice, or residential health care facility; or (b) continuing treatment or continuing supervision by a health care provider. A serious health condition involving continuing treatment or continuing supervision by a health care provider requires any one or more of the following:




More than 3 consecutive full days of inability to work, attend school, perform regular activities, or other incapacity due to a condition, plus any subsequent treatment or period of incapacity that involves treatment two or more times, or treatment at least once that results in a regimen of continuing treatment under the supervision of a health care provider.

Any period of inability to work, attend school, perform regular activities, or other incapacity due to a chronic serious health condition that requires periodic visits for treatment by a health care provider, continues over an extended period of time (including recurring episodes of an underlying condition), and may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy).

A long-term or permanent period of inability to work, attend school, perform regular activities, or other incapacity due to a condition for which treatment may not be effective (e.g., Alzheimer's, severe stroke, or terminal disease). The family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider.

A period of inability to work, attend school, perform regular activities, or other incapacity due to treatment (including any period of recovery therefrom) by a health care provider for restorative surgery, or for a condition that would likely result in more than 3 consecutive full days of incapacity without treatment (e.g., cancer, severe arthritis, kidney disease).

QUALIFYING EXIGENCY. For purposes of both FMLA and NYPFL, "qualifying exigency" means a situation arising out of the fact that the caregiver's spouse, child, or parent is a military member in the United States Armed Forces, Reserves, or National Guard on covered active duty or who has been notified of an impending call or order to covered active duty status ("Military Member").

"Covered active duty," for members of the Regular Armed Forces, means duty during deployment of the Military Member with the Armed Forces to a foreign country. "Covered active duty," for members of National Guard or Reserves, means duty during the deployment of the Military Member with the Armed Forces to a foreign country under a call or order to active duty in support of a "contingency operation," as defined by law.

# QUALIFYING EXIGENCY

A "qualifying exigency" exists where one of the following events occurs:



SHORT-NOTICE DEPLOYMENT. To address any issue that arises from the fact that the Military Member is notified of an impending call or order to covered active duty, for a period of seven (7) or less calendar days from the date of notification;

MILITARY EVENTS AND RELATED ACTIVITIES. To attend any official ceremony, program, or event sponsored by the military that is related to the covered active duty or call to covered active duty status of the Military Member, or family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the covered active duty or call to covered active duty status of the Military Member;

CHILDCARE AND SCHOOL ACTIVITIES. To attend to certain childcare and school activities that are necessitated by the Military Member's active duty or call to active duty status, such as: (i) arranging for alternative childcare; (ii) providing childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis); (iii) enrolling in or transferring to a new school or daycare facility; and (iv) attending meetings with caregivers at a school or daycare facility;

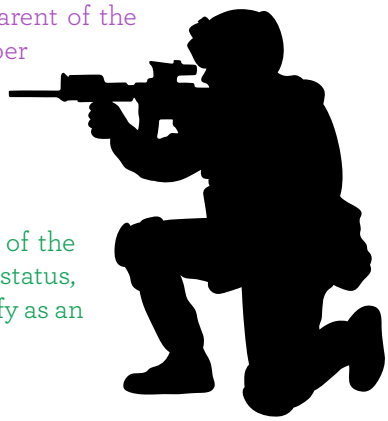
FINANCIAL AND LEGAL ARRANGEMENTS. To make or update financial and legal arrangements to address the Military Member's absence while on covered active duty or call to covered active duty status;

COUNSELING. To attend counseling provided by someone other than a health care provider, for oneself, for the Military Member, or for the biological, adopted, or foster child, a stepchild, or a legal ward of the Military Member, or a child for whom the Military Member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence, provided that the need for counseling arises from the covered active duty or call to covered active duty status of the Military Member;

REST AND RECUPERATION. To spend time with a Military Member who is on short-term, temporary, rest and recuperation leave during deployment for up to fifteen (15) calendar days;

POST-DEPLOYMENT ACTIVITIES. To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the Military Member's covered active duty status; and to address issues that arise from the death of a Military Member while on covered active duty status;

PARENTAL CARE. To provide certain care to a Military Member's parent who is incapable of self-care, and where each instance of the care provided is necessitated by the Military Member's covered active duty. Covered activities provided to the parent of a Military Member under this provision include: (1) arranging for alternative care for a parent of the Military Member; (2) providing care for a parent of the Military Member on an urgent, immediate need basis; (3) admitting or transferring the parent of a Military Member to a care facility; and (4) attending meetings with caregivers at a care facility where the parent of a Military Member resides or stays; or



ADDITIONAL ACTIVITIES. To address other events which arise out of the Military Member's covered active duty or call to covered active duty status, provided that the Agency and caregiver agree that such leave shall qualify as an exigency, and both agree to the timing and duration of such leave.

# FMLA
## MILITARY CAREGIVER LEAVE

For purposes of Military Caregiver Leave under the FMLA, "Covered Service member" means:

A current member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness ("Current Service member");" or

A veteran who: (1) is undergoing medical treatment, recuperation, or therapy for a serious injury or illness; (2) was a member of the Armed Forces (including a member of the National Guard or Reserves); (3) was discharged within the five-year period before the eligible caregiver first takes FMLA leave to care for him or her; and (4) was discharged or released from the Armed Forces under conditions other than dishonorable ("Covered Veteran"). An eligible caregiver must commence leave to care for a Covered Veteran within five years of the Covered Veteran's active duty service.

For purposes of Military Caregiver Leave under the FMLA "serious injury or illness" means:
In the case of a Current Service member, an injury or illness that was incurred by him or her in the line of duty on active duty in the Armed Forces (or that existed before the beginning of his or her active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and that may render the Covered Service member medically unfit to perform the duties of his or her office, grade, rank, or rating; and

In the case of a Covered Veteran, an injury or illness that was incurred or aggravated by him or her in the line of duty, while on active duty in the Armed Forces, and which manifested itself before or after he or she became a veteran, and is:

A continuation of a serious injury or illness that was incurred or aggravated when the Covered Veteran was a member of the Armed Forces and rendered him or her unable to perform the duties of his or her office, grade, rank, or rating;

A physical or mental condition for which the Covered Veteran has received a VA Service Related Disability Rating ("VASRD") of 50 percent or greater and such VASRD rating is based, in whole or in part, on the condition precipitating the need for leave;

A physical or mental condition that substantially impairs the Covered Veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service or would do so absent treatment; or

An injury, including a psychological injury, on the basis of which the Covered Veteran has been enrolled in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

Important limitation: If a caregiver does not take all of his or her 26 workweeks of leave entitlement to care for a Covered Service member during the 12-month period, the remaining part of his or her 26 workweeks of leave is forfeited.

Maximum duration of leave in any 12-month period: The Military Caregiver Leave is applied on a per-Covered-Service member, per-injury, basis such that a caregiver may be entitled to take more than one period of 26 work weeks of leave if the leave is to care for different Covered Service members or to care for the same Covered Service member with a subsequent serious injury or illness, except that no more than 26 workweeks of leave my be taken within any single 12-month period.

# FMLA
## MILITARY CAREGIVER LEAVE

"Next of kin": A caregiver is "next of kin" of a Covered Service member if he or she is the nearest blood relative of the Covered Service member *(other than the Covered Service member's spouse, parent, or child)*. Unless the Covered Service member has specifically designated in writing a particular blood relative as his or her nearest blood relative for the purposes of the Military Caregiver Leave, the following is the order of priority used to identify the nearest blood relatives of the Covered Service member:

(a) blood relatives who have been granted legal custody of the Covered Service member;

(b) siblings;

(c) grandparents;

(d) aunts and uncles; and

(e) first cousins



When no such designation is made, and there are multiple family members with the same level of relationship to the Covered Service member, all such family members shall be considered the Covered Service member's next of kin and may take FMLA leave to provide care to the Covered Service member, either consecutively or simultaneously. When such designation has been made, the designated individual shall be deemed to be the Covered Service member's only next of kin.

# INTERMITTENT AND REDUCED SCHEDULE LEAVE

If medically necessary, FMLA leave occasioned by a serious health condition may be taken intermittently *(in separate blocks of time due to a serious health condition)* or on a reduced leave schedule *(reducing the usual number of hours you work per workweek or workday)*. Medically necessary means that there must be a medical need for the leave and the leave can best be accomplished through an intermittent schedule. FMLA leave may also be taken intermittently or on a reduced leave schedule for a qualifying exigency relating to covered military service.

If FMLA leave taken intermittently is unpaid, the Company will reduce the caregiver's salary based on the amount of time actually worked.

In addition, while a caregiver is on an intermittent or reduced schedule leave, the Company may temporarily transfer him or her to an available alternative position that better accommodates his or her leave schedule and has equivalent pay and benefits.

When intermittent FMLA leave is needed to care for an immediate family member or the caregiver's own illness, and is for planned medical treatment, the caregiver must attempt to schedule treatment so as to minimize disruption to the Company's operations. Caregivers should consult with the Company prior to scheduling the treatment in order to arrange a schedule that best suits the needs of the caregiver and the Company.

**NYPFL** Eligible caregivers may take intermittently in no less than daily increments. The maximum number of days of NYPFL available to a caregiver is calculated based on the average number of days the caregiver works per week. For example, a worker with a schedule of 5+ days per week can take up to the then-applicable maximum weeks of leave multiplied by 5 days (in 2018, the maximum is 8 weeks, so the worker would be eligible for up to 40 days of leave in a 52-week period). For a caregiver who works 3 days per week (60% of the work week) can receive only 60% of the then-applicable maximum leave (in 2018, this would be 60% of 40 days, so the caregiver would be eligible for up to 24 days of leave in a 52-week period).

# FMLA / NYPFL

**CONCURRENT LEAVE.**

Where FMLA and NYPFL run concurrently, intermittent leave will be immediately deducted from the caregiver's FMLA entitlement. Because intermittent NYPFL is measured in daily increments, intermittent leave will be deducted from the caregiver's NYPFL entitlement each time the hours taken under FMLA add up to the number of hours in a caregiver's usual work day.

# NYPFL CONTRIBUTIONS AND WAIVERS

CONSISTENT WITH THE NYPFL LAW, THE COMPANY WILL FUND THE NYPFL INSURANCE POLICY THROUGH DEDUCTIONS FROM THE PAY OF ALL CAREGIVERS, EXCEPT THOSE WHO HAVE FILED VALID WAIVERS IN ACCORDANCE WITH THIS POLICY. THE COMPANY WILL MAKE THE MAXIMUM DEDUCTIONS PERMITTED BY LAW.

CAREGIVERS WHOSE REGULAR SCHEDULE IS 20 OR MORE HOURS PER WEEK BUT WHO WILL NOT WORK 26 CONSECUTIVE WEEKS, AND CAREGIVERS WHOSE REGULAR SCHEDULE IS LESS THAN 20 HOURS PER WEEK AND WHO WILL NOT WORK 175 DAYS IN A 52-CONSECUTIVE-WEEK PERIOD, MAY FILE A WAIVER OF NYPFL BENEFITS. UPON FILING A WAIVER, THE CAREGIVER WILL BE EXEMPT FROM MAKING CONTRIBUTIONS TO NYPFL AND THUS WILL NOT BE SUBJECT TO PAYROLL DEDUCTIONS. HOWEVER, THE CAREGIVER WILL BE INELIGIBLE FOR NYPFL BENEFITS.

IF THE WORK SCHEDULE OF A CAREGIVER WHO HAS FILED A WAIVER CHANGES SO THAT HE OR SHE WILL WORK 26 CONSECUTIVE WEEKS, OR 175 DAYS IN A 52-CONSECUTIVE-WEEK PERIOD, THE WAIVER WILL BE AUTOMATICALLY REVOKED WITHIN 8 WEEKS OF THE CHANGE. THE CAREGIVER WILL THEN BE OBLIGATED TO MAKE CONTRIBUTIONS, INCLUDING ANY RETROACTIVE AMOUNTS DUE FROM DATE OF HIRE.

# APPLICATION
## FOR FMLA LEAVE AND/OR NYPFL

To take FMLA leave or NYPFL, a caregiver must provide the Company with advance notice of the need for leave as follows:

**FORESEEABLE LEAVE.** Where the need for leave is foreseeable *(e.g., planned medical treatment, expected birth or placement of a child, planned medical treatment for a serious injury or illness of a family member, etc.)*, a caregiver must provide the Company with at least 30 days advance notice of the need for leave.

If 30 days advance notice is not possible *(e.g., because of lack of knowledge of approximately when the leave will be required to begin, a change in circumstances, or a medical emergency)*, the caregiver must at least provide notice as soon as practicable under the circumstances. Normally, it should be practicable for the caregiver to provide notice of the need for leave either the same day he or she becomes aware of a qualifying event or the next business day.

Whether FMLA leave is to be continuous or is to be taken intermittently or on a reduced schedule basis, notice need only be given one time, but the caregiver shall advise the Company as soon as practicable if dates of scheduled leave change or are extended or were initially unknown. To qualify for NYPFL, caregivers must provide the Company with notice as soon as possible before **each day** of intermittent leave.

# FMLA / NYPFL

**UNFORESEEABLE LEAVE.** When the approximate timing of the qualifying event and the need for leave is not foreseeable, the caregiver must provide notice as soon as practicable under the facts and circumstances of the qualifying event. Absent unusual circumstances, it generally should be practicable for the caregiver to provide notice 2 hours before a scheduled shift as required by the Company's policy. **It should generally be practicable for the caregiver to provide notice within two business days after learning of the need for leave.**

A caregiver who fails to provide advance notice in compliance with these policies must explain to the Company why he or she was unable to do so. Absent unusual circumstances, a caregiver's failure to follow these policies will result in FMLA leave and/or NYPFL being denied or delayed.

The notice rules apply to **each day** of intermittent leave under the NYPFL. If a caregiver is planning a medical treatment or a series of treatments under FMLA or NYPFL or is taking Military Caregiver Leave under the FMLA, he or she must consult with the Company first regarding the dates of such treatment to work out a schedule that best suits the needs of both the caregiver or the Covered Military Member, if applicable, and the Company.

Applications for leave under FMLA and/or NYPFL should be submitted in writing to the Benefits Administrator. Application forms are available in the Human Resources Department. In addition, caregivers seeking NYPFL will be required to file a claim with the Company's NYPFL insurance carrier *(see NYPFL Claim and Certification Procedure section, below)*.

Failure to provide proper notice of your need for FMLA leave and/or NYPFL may result in the denial or delay of protected leave, depending on the particular facts and circumstances.



# FMLA CERTIFICATION PROCEDURE

If a caregiver is requesting FMLA leave because of his or her own or a covered relation's serious health condition, the caregiver and the relevant health care provider must supply appropriate medical certification. Caregivers may obtain Medical Certification forms from the Human Resources Department. When a caregiver requests leave, the Company will notify him or her of the requirement for medical certification and when it is due (at least 15 days after leave is requested). If the caregiver provides at least 30 days' notice of medical leave, he or she should also provide the medical certification before leave begins. Failure to provide requested medical certification in a timely manner may result in denial of FMLA- covered leave until it is provided.




The Company, at its expense, may require an examination by a second health care provider designated by the Company. If the second health care provider's opinion conflicts with the original medical certification, the Company, at its expense, may require a third, mutually agreeable, health care provider to conduct an examination and provide a final and binding opinion. The Company may require subsequent medical recertification. Failure to provide requested certification within the required timeframe may result in delay of further leave until it is provided.

The Company also reserves the right to require certification from a covered military member's health care provider if a caregiver is requesting military caregiver leave and certification in connection with military exigency leave.

## NYPFL Claim and Certification Procedure

To obtain NYPFL benefits, you must file a claim with the Company's NYPFL insurance carrier on the carrier's prescribed form(s). The caregiver will also be required to provide the NYPFL insurance carrier with sufficient certification of the need for leave and supporting documentation as provided by the NYPFL Law, the relevant insurance policy, and the carrier's own requirements. For example, the caregiver may be required to provide:

- **Certification from a health care provider regarding the serious health condition for which the caregiver needs leave**
- **Documentation such as a birth certificate establishing the birth of a child**
- **Documentation such as court documents or placement letters establishing that the caregiver is in the process of adopting or has adopted a child or is fostering a child**
- **Certification of military exigencies and supporting military orders**

When you inform the Company of the need for NYPFL, the Company will provide you with a copy of the relevant claim form(s) and complete any employer portion(s). You can also obtain and file the claim form(s) directly through our NYPFL insurance carrier,

GUARDIAN, VIA PHONE: **888-482-7342**, WEBSITE: **WWW.GUARDIANLIFE.COM**

Contact the carrier if you have any questions about the forms and documents you must submit in support of your claim for benefits.

# REPORTING WHILE ON LEAVE

While you are on NYPFL, you should notify the Company and/or the NYPFL insurance carrier as soon as practicable *(within two business days, if feasible)* if there is any change in your circumstances or if your dates of leave change or were initially unknown and become known or estimated.

## CONDITIONS OF FMLA LEAVE AND NYPFL

The following conditions apply to leave taken under FMLA and/or NYPFL pursuant to this policy, except where otherwise required by applicable law:

A caregiver taking an approved leave of absence may not engage in other work or employment during the leave of absence. If a caregiver engages in other work or employment during the leave of absence, the caregiver will be considered to have violated the terms of the leave of absence, and to have voluntarily terminated his or her employment with the Company.

A caregiver on approved leave who fails to return to work at the end of his or her leave will be required to reimburse the Company for all health insurance premium payments expended by the Company on the caregiver's behalf during the leave, unless the reason the caregiver does not return to work is due to: **(a)** the continuation, recurrence, or onset of a serious health condition of the caregiver or the caregiver's spouse, son, daughter, or parent; **(b)** the serious injury or illness of a spouse, son, daughter, or parent, or next of kin, who is a Covered Service member; or **(c)** other circumstances beyond the caregiver's control.

Caregivers will not receive holiday pay during leave except as required by applicable law.

A caregiver may be subject to termination during a leave for reasons including but not limited to falsification of reason for or status of the circumstances surrounding the leave of absence.

If business conditions require a reduction in force, caregivers on an approved leave of absence will be considered for lay-off and treated in the same manner as active caregivers.

# COMPENSATION AND BENEFITS DURING FMLA/NYPFL

## Compensation during FMLA

As noted above, FMLA leave is unpaid. However, nothing in this policy prevents a caregiver from applying for worker's compensation or NYS Disability benefits. Leave which is covered by workers' compensation or disability benefits will be designated as FMLA leave to the maximum extent permitted by law.

Caregivers not receiving workers' compensation, disability *(including NYS short term disability)*, or NYPFL benefits will be required to use their accrued Sick hours during FMLA leave, and such leaves will run concurrently with the caregiver's FMLA leave. Caregivers will also be required to use any accrued sick hours during any waiting periods for disability benefits or workers' compensation benefits.

## Compensation during NYPFL

As noted above, NYPFL is paid by the Company's NYPFL insurance carrier in accordance with the insurance policy, the maximum benefits set forth in the law, and the carrier's own rules and procedures.

Where leave is taken under NYPFL, the caregiver may but is not required to use accrued sick hours during the leave. Use of accrued sick hours will allow the caregiver to receive full pay during the leave until paid time off is exhausted.

Where a caregiver is paid for accrued sick hours during NYPFL *(whether concurrent with FMLA or not)*, the Company will be entitled to receive the NYPFL payment from the NYPFL carrier as reimbursement for the NYPFL portion of the amount paid to the caregiver. In no event shall a caregiver's use of accrued sick hours during NYPFL result in the caregiver's receipt of more than 100% his or her average weekly wage.

## Health Insurance during FMLA and/or NYPFL

To the extent required by law, the Company will maintain group health insurance benefits for caregivers on FMLA leave and/or NYPFL on the same basis as coverage would have been provided if the caregiver had been actively working during the leave period. Any share of group health plan premiums which had been paid by the caregiver prior to leave must continue to be paid by the caregiver during the leave period. Where the caregiver is receiving pay directly from the Company *(i.e., using sick, personal, or vacation time)*, deductions for group health insurance will continue to be made on the same basis as if the caregiver was actively working. Where the caregiver is not receiving pay from the Company, arrangements will be made for caregivers to pay their share of the group health insurance premiums while on leave. If the Company pays the caregiver's share of any premium payments, the Company reserves the right to recover the full value of those payments made in any manner permitted by law.

A caregiver whose health insurance coverage is maintained pursuant to this policy during an approved FMLA and/or NYPFL leave will be subject to any changes in the Company's group health plan that occur while he or she is on leave *(e.g., changes in coverage, premiums, deductibles)*.

If a caregiver's premium payment is more than thirty (30) days late while the caregiver is on FMLA leave and/or NYPFL, his or her group health insurance benefits may be terminated, and the caregiver will be extended continuing coverage opportunities in accordance with COBRA. However, if coverage is terminated for this reason and the caregiver returns to work from FMLA leave, the caregiver's group health insurance benefits will be reinstated, to the same extent the caregiver would have been entitled to those benefits had he or she not taken leave.

If a caregiver gives unequivocal notice of his or her intent not to return to work, the Company's obligation to continue group health insurance benefits will cease, subject to COBRA.

# FMLA / NYPFL

## Other Benefits

An approved FMLA leave and/or NYPFL pursuant to this policy will not result in the loss of any employment benefit that may have accrued before the date the leave of absence started. For all periods when a caregiver uses accrued sick hours concurrently with FMLA or NYPFL, benefits that are accumulated on an accrual basis will continue to accrue to the extent they would have otherwise, and deductions for group health insurance will continue to be made on the same basis as if the caregiver was not on leave. Caregivers will not accrue or receive any benefits *(other than group health insurance benefits as noted above)* for periods where FMLA and/or NYPFL is not run concurrently with use of the caregiver's accrued sick hours.

## Return from an Approved FMLA Leave and/or NYPFL

Unless the caregiver's employment was or would have been terminated for reasons unrelated to the leave *(e.g., reorganization, lay off, reduction in force, etc.)*, the Company will restore a caregiver who returns from approved FMLA and/or NYPFL leave to the same position that the caregiver held prior to the leave or to an equivalent position with substantially similar duties, conditions, responsibilities, privileges, and status as the original position, subject to the terms, limitations, and exceptions provided by law.

Before returning from an approved FMLA leave granted as a result of a caregiver's own serious health condition, a caregiver must present a written fitness-for-duty certification from his or her medical care provider. A caregiver's failure to provide such certification at the time the caregiver attempts to return to work may result in a delay or denial of job restoration.

Caregivers are expected to return to work when the FMLA leave and/or NYPFL ends, unless a caregiver requests and is granted an extension of leave as an accommodation or pursuant to another Company policy. If a caregiver does not return to work on the agreed upon date after expiration of FMLA leave and/or NYPFL, and an extension of leave was not granted to the caregiver, the caregiver will be considered to have voluntarily terminated his or her employment.

With respect to certain "highly paid" or "key" caregivers, there may be specified and limited circumstances under which the Company may refuse to reinstate such individuals following FMLA leave. This determination will be made in accordance with applicable law.



## FURTHER INFORMATION

Caregivers wanting further information regarding this policy should consult with the Human Resources Department.

The Company will not interfere with, restrain, or deny a caregiver the exercise of any right provided under the FMLA or discriminate against any person for opposing any practice made unlawful by the FMLA or for being involved in any proceeding under or relating to the FMLA. If a prohibited act has occurred, or the FMLA was not followed, a complaint may be filed with the United States department of labor or a private action instituted.

The Company will not discriminate or retaliate against a caregiver because he or she claimed NYPFL benefits, attempted to claim NYPFL benefits, or testified or is about to testify in a proceeding under the NYPFL Law.

This policy is intended to implement the FMLA and the NYPFL and their accompanying regulations. To the extent this policy is inconsistent therewith, the law and regulations will govern. Further, to the extent any state or local law provides for additional leave benefits, the Company will comply with any such requirements.

# SICK DAYS

## CALLING OUT SICK? HERE'S WHAT TO DO:



1. Let us know ASAP if you're not feeling well.

2. If you need to reach us outside of office hours, call 845-425-6555 and press '0' to reach the answering service.

   Your coordinator will call you back to discuss the situation. If you did not receive a call back, we did not receive your message. So please call again.

3. You MUST specify which shifts you'll be missing.

   If you only mention one shift,
   **YOU WILL BE EXPECTED TO SHOW UP TO THE NEXT SHIFT.**

4. Let us know when you'll be back to work.

   If you are not returning next day, make sure to notify the agency by 5pm.
   If not, we will automatically assume that you are going to work the next day.

5. Remember, you must ask your coordinator to apply your accumulated sick time to be paid for your time off.
   If you do not have any accumulated sick time, the absence will be unpaid.

6. Need more time off? Just ask your Coordinator!

   If your situation requires you to be out for more than 7 days, please contact Staff HR to discuss your situation.

7. Keep us updated on your status so we can support you!

*The Agency may request additional information from you at that point. You are expected to work with your Coordinator and/or other Agency Representative who is requesting the information to evaluate your leave request. To the extent the leave from work is granted,caregivers must keep their Coordinator apprised of their circumstances and ongoing leave from work at least weekly (unless a different arrangement is made pursuant to FMLA or other laws). Failure to provide timely updates will lead to termination based on job abandonment.*

## PAID SICK TIME POLICY FOR NEW YORK STATE

**Accrual:** Caregivers earn 1 hour of sick leave for every 30 hours worked, up to 56 hours per calendar year.

Balance inquiries can be directed to the Time off team at (845) 280-9522.

**Pay:** Sick time is paid at the regular wage, up to the scheduled shift hours (max 8 or 12 hours) and is included in the next regular payroll period after use.

**Annual Limit:** A maximum of 56 hours of sick leave can be used per calendar year.

**Carryover:** Up to 56 hours of unused sick leave can be carried over to the next year, but not paid out.

**Incremental Use:** Sick leave can be used as it's accrued and in the following increments:

- 4-hour minimum
- 30-minute increments beyond 4 hours

**SICK TIME USAGE:** Employees are entitled to utilize accrued leave for scheduled cases upon submitting a verbal or written request to their employer only for authorized uses under NYS law, including:

1. To address their own mental or physical illness, injury, or health condition, regardless of diagnosis or medical care requirements at the time of the request.
2. To facilitate the diagnosis, care, treatment, or preventive care of their own mental or physical illness, injury, or health condition, including recovery from COVID-19 vaccination side effects.
3. To provide care or assistance to a family member (as defined below) for their mental or physical illness, injury, or health condition.
4. Closure of caregiver's workplace or childcare facility due to a public health emergency (as declared by the Commissioner of the New York City Department of Health and Mental Hygiene or the Mayor.)
5. "Safe time." As defined by New York State, New York City or Westchester County laws.

*See "safe time leave" for more details of acceptable reasons and documentation.*

# SICK DAYS

**Definition of Family Member:** For the purposes of this policy, a family member includes:

- Children: biological, adopted, foster, legal wards, or children of a caregiver standing in loco parentis
- The child or parent of a caregiver's spouse or domestic partner
- Spouse or domestic partner
- Parents, grandparents or grandchildren
- Siblings (including half, adopted, or step-siblings)

**Notice & Documentation Requirements:**

- Provide as much notice as possible for foreseeable absences (minimum 7 calendar days)
- Notify Coordinator as soon as possible for emergencies or sudden conditions
- Failure to give proper notice, when possible, may result in disciplinary action.
- A caregiver may be asked to confirm, in writing or otherwise, that sick time was taken pursuant to the NY Sick Leave law or Westchester Sick Leave law.
  - ➢ Use of sick time for reasons not covered by the NY Sick Leave law or Westchester Sick Leave law will be subject to disciplinary action.
- For 3 or more consecutive workdays of sick time, the company may request that you provide a doctor's note from your health care professional. The doctor's note does not need to include a diagnosis or medical details.

**Payment and Termination:** Sick time will not be paid out upon voluntary or involuntary termination of employment.

**Excessive Absenteeism** (apart from proper use of Sick Leave), failure to properly notify in advance of leave (except where not possible in circumstances like emergencies), or patterned absences may be subject to disciplinary action.

**Balance Inquiries** can be directed to the Time off team at (845) 280-9522.
Please feel free to contact Human Resources with any questions you may have about the Paid Sick Leave policies at (845) 203-1734.

## SCHEDULED TIME OFF (VACATION/PERSONAL TIME)

➜ Employees may also use available hours for scheduled time off, including vacation or personal reasons.

› Requests for scheduled time off must be submitted at least 2 weeks in advance using the company's time off request form.

- Failure to obtain advance approval may result in the time off being treated as an unscheduled absence.

› Approval is subject to staffing needs and operational coverage.

### Distinction Between Sick Time and Scheduled Time Off

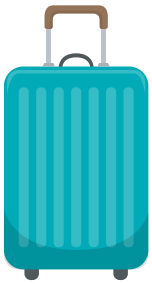
➜ Although sick time and scheduled time off are drawn from the same bank:

› Rules apply based on how time is used, not the total number of hours taken.

› Pre-approved vacation or personal time is not treated as sick time and is not subject to medical documentation requirements.

› Unplanned absences due to illness are treated as sick time and subject to applicable NYS rules.

# SAFE TIME LEAVE



## WESTCHESTER COUNTY

Under Westchester County's Safe Time Leave Law, Community Home Health Care is required to give their covered employees paid safe time leave to attend or testify in a criminal or civil court proceeding relating to domestic violence or human trafficking or to move to a safe location. Employees covered by the Safe Time Leave Law must give written notice by filling out a time off request form and provide proper documentation. Community will allow you to take up to 40 hours of safe time leave per calendar year in full days or increments. No accrual is needed for safe time leave in Westchester county. Leave provided under the Safe Time Leave Law shall be in addition to sick leave provided in Westchester county.

Employees who have already worked for Community Home Health Care for 90 days by October 30, 2019, are eligible to take safe time leave as of October 30, 2019. Newly or recently hired caregivers to become eligible to take safe time leave 90 days after the first date of employment.

### ACCEPTABLE REASONS TO USE SAFE TIME LEAVE

If you are a victim of domestic violence or a victim of human trafficking, you may use safe time leave to:

- **Attend or testify in criminal or civil court proceedings relating to domestic violence;**
- **Attend or testify in criminal or civil court proceedings relating to human trafficking; and/or**
- **Move to a safe place.**

### ADVANCE NOTICE

If the need is foreseeable, you must make a good faith effort to provide notice of your intention to use safe time leave. Community requires employees to provide reasonable documentation along with the time off request form that the safe time leave will be, or has been used, for a purpose covered under the Safe Time Leave Law. Such documentation may include a court appearance ticket or subpoena, a copy of a police report, an affidavit from an attorney involved in the court proceeding, or an affidavit from an authorized person from a reputable organization known to provide assistance to victims of domestic violence or human trafficking. Any information about an employee or family member obtained solely for the purposes of utilizing safe time leave shall be treated as confidential and shall not be disclosed except with the written permission of the affected employee unless such disclosure is otherwise required by law. Community will maintain this information on a separate form and in a separate file from other personnel information.

## NEW YORK CITY

Community Home Health Care is required to give their covered employees paid safe time leave when the Employee or Employee's family member has been the victim of domestic violence, a family offense matter, sexual offense, stalking, or human trafficking. Where such leave is foreseeable, Employees must give advanced written notice of the intention to use such safe leave by filling out a time off request form. Where such leave is unforeseeable, Employees must give written notice of the need for the use of safe time by filling out a time off request form, as soon as practicable. Employees will accrue one hour of safe/sick time for every thirty hours worked, which can result in a maximum of 56 hours accrued for safe/sick time. Community will allow you to take up to 56 hours of safe/sick time leave per calendar year in full days or increments. Employees must take safe leave in minimum of 4 hour increments.

Employees begin to accrue safe/sick time at the commencement of the employment or January 1, 2021, whichever is later.

### ACCEPTABLE REASONS TO USE SAFE TIME LEAVE

- **To obtain services from a domestic violence shelter, rape crisis center, or other shelter or services program for relief from a family offense matter, sexual offense, stalking, or human trafficking;**
- **To participate in safety planning, temporarily or permanently relocate, or take other actions to increase the safety of the employee or employee's family members from future family offense matters, sexual offenses, stalking, or human trafficking;**
- **To meet with an attorney or other social services provider to obtain information and advice on, and prepare for or participate in any criminal or civil proceeding, including but not limited to, matters related to a family offense matter, sexual offense, stalking, human trafficking, custody, visitation, matrimonial issues, orders of protection, immigration, housing, discrimination in employment, housing or consumer credit;**
- **To file a complaint or domestic incident report with law enforcement;**
- **To meet with a district attorney's office;**
- **To enroll children in a new school; or**
- **To take other actions necessary to maintain, improve, or restore the physical, psychological, or economic health or safety of the employee or the employee's family member or to protect those who associate or work with the employee.**

### REASONABLE DOCUMENTATION

For an absence of more than three consecutive work days for safe time, Community require reasonable documentation that the use of safe time was authorized. Such reasonable documentation may include: a signed document by an employee, agent, or volunteer of a victim services organization, an attorney, a member of the clergy, or a medical or other professional service provider

# SAFE TIME LEAVE

from whom the Employee or that Employee's family member has sought assistance in addressing domestic violence, family offense matters, sex offenses, stalking, or human trafficking and their effects; a police or court record; or a notarized letter from the Employee explaining the need for such time. Such documentation is not required to specify the details of the domestic violence, family offense matter, sexual offense, stalking, or human trafficking. Community will reimburse an employee for all reasonable costs or expenses incurred for the purpose of obtaining such documentation. Any information about an Employee or an Employee's family member obtained solely for the purposes of utilizing safe time leave shall be treated as confidential and shall not be disclosed except with the written permission of the affected Employee unless such disclosure is otherwise required by law.



## RETALIATION

Community shall not take any adverse action against an Employee that penalizes an Employee for, or is reasonably likely to deter an Employee from, exercising or attempting to exercise safe/sick leave or interfere with an employee's exercise of such rights. Employees whose rights have been violated can file a complaint with the NYC Department of Consumer and Worker Protection and/or the New York State Department of Labor.

## CHANGES TO THE NEW YORK CITY EARNED SAFE AND SICK TIME AND TEMPORARY SCHEDULE CHANGE ACTS GO INTO EFFECT FEBRUARY 22, 2026

The New York City Earned Safe and Sick Time Act (ESSTA) requires employers to provide safe and sick time to employees working in New York City. The new amendments will require employers to provide 32 hours of unpaid safe and sick time to employees immediately upon hire and at the start of each calendar year with no waiting period for use. Unused unpaid leave will not carry over into the following year and, if available, paid safe and sick time must be utilized before unpaid safe and sick time unless specifically requested by the employee. Additionally, the reasons for use for safe and sick time have been expanded to include caregiving of minor child or care recipient, pursuit of subsistence benefits or housing, workplace violence, and public disasters. Further, in addition to paid safe and sick time, employers are required to provide 20 hours of paid prenatal leave during any 52-week calendar period. Changes to the ESSTA's collective bargaining provisions now allow ESSTA to be waived where a collective bargaining agreement provides for "superior or comparable benefits" in the form of paid or unpaid time off.

## NEW YORK STATE

Community Home Health Care is required to give their covered Employees paid safe time leave when the Employee or Employee's family member has been the victim of domestic violence, a family offense matter, sexual offense, stalking, or human trafficking. Where such leave is foreseeable, Employees must give advanced written notice of the intention to use such safe leave by filling out a time off request form. Where such leave is unforeseeable, Employees must give written notice of the need for the use of safe time by filling out a time off request form, as soon as practicable. Employees will accrue one hour of safe/sick time for every thirty hours worked, which can result in a maximum of 56 hours accrued for safe/sick time. Community will allow you to take up to 56 hours of safe/sick time leave per calendar year in full days or increments. Employees must take safe leave in minimum of 4 hour increments.

Employees begin to accrue safe/sick time at the commencement of the employment or January 1, 2021, whichever is later.

## ACCEPTABLE REASONS TO USE SAFE TIME LEAVE

- **To obtain services from a domestic violence shelter, rape crisis center, or other services program;**
- **To participate in safety planning, temporarily or permanently relocate, or take other actions to increase the safety of the employee or employee's family members;**
- **To meet with an attorney or other social services provider to obtain information and advice on, and prepare for or participate in any criminal or civil proceeding;**
- **To file a complaint or domestic incident report with law enforcement;**
- **To meet with a district attorney's office;**
- **To enroll children in a new school; or**
- **To take any other actions necessary to ensure the health or safety of the employee or the employee's family member or to protect those who associate or work with the employee.**

## DOCUMENTATION

For an absence of three or more consecutive work days or shifts for safe time, Community requires an attestation from an employee of their eligibility to safe leave. Employees are not required to provide any confidential information, including any details or information regarding safe leave. The attestation is NOT required to explain any details related to domestic violence, sexual offense, family offense, human trafficking, or stalking that necessitates the use of safe leave.




## RETALIATION

Community shall not take any adverse action against an Employee that penalizes an Employee for, or is reasonably likely to deter an Employee from, exercising or attempting to exercise safe/sick leave or interfere with an employee's exercise of such rights. Employees whose rights have been violated can file a complaint with the New York State Department of Labor.

# LEAVE OF ABSENCE

To request leave, please submit a written notice at least two weeks in advance. We allow up to three months' absence, with the option to extend it in writing. If eligible, leaves will be designated under FMLA, NYS Paid Family Leave, or other applicable laws.

## UNPAID LEAVE

If not covered by law or after exhausting entitlements, we offer up to six months of unpaid leave, subject to reasonable accommodation and no undue hardship. Time off requests must be approved by the Coordinator and done at least two (2) weeks in advance. Your request may be declined if there is not adequate coverage.

## MEDICAL LEAVE

We may request medical information to verify your condition and need for leave. Failure to provide this information may delay or deny your request. Consistent with applicable law, the Agency also reserves the right to require caregivers to submit to an examination by a medical professional it selects.

## BENEFITS DURING LEAVE

You can use accrued paid time off, or sick time if medically related, during your leave. You may also be eligible for short-term or long-term disability benefits and can continue group health benefits at your own expense. Please note, all benefits that operate on an accrual basis (e.g., paid time off) will cease to accrue during any portion of leave that is unpaid.

## RETURNING TO WORK

Upon your return to work, the Agency will make every effort to provide you with work as close to or as similar as you had before your leave. **THERE IS NO GUARANTEE THAT YOU WILL RETURN TO YOUR PREVIOUS PATIENT.**

Before returning, you must:

→ Complete any missed in-services

→ Rectify compliance issues, if applicable

→ Provide medical information and/ or undergo a medical examination (if required)

→ Receive approval from Human Resources

**FAILURE TO COMPLY MAY RESULT IN TERMINATION.**

## ADDITIONAL ITEMS OF NOTE

- If you are away or out of the country, you are still responsible for contacting the office.
- Failure to return to work on the scheduled date will result in termination. If rehired later, the individual will be treated as a new employee, requiring new documentation, benefits according to new hire policies, and wages determined by current pay scales.
- If a caregiver is unable to return to work following the exhaustion of the leave provided under this policy, the caregiver will be deemed to have abandoned his or her job, except for caregivers who were on a leave of absence due to a disability. For such caregivers, the caregiver must request and receive an accommodation under the Agency's Americans with Disabilities Act policy. Each request for such an accommodation under the ADA policy will be evaluated on a case-by-case basis, and the Agency may request appropriate medical information to verify the caregiver's medical condition and need for additional leave. Failure to provide the information requested may result in the delay or denial of the requested leave.
- If a caregiver's leave request lacks a specific return date or requires additional leave, the Agency may request periodic updates on their condition and expected return date.

# NURSING MOTHERS

In consideration of working mothers who may be lactating, the Agency will provide a reasonable amount of break time to accommodate a caregiver desiring to express breast milk for her child *(from infancy up to three years of age)*. If possible, lactation breaks should be taken during the breaks already provided to the staff member. Any additional breaks taken to express milk may be unpaid.



A caregiver who needs lactation breaks should speak to the Coordinator and the patient to arrange for break time so that reasonable efforts can be made to provide a room or other location for the caregiver to express milk in private. The Agency prohibits discrimination on the basis of the need to express breast milk.

Caregivers may be able to begin work before the regularly scheduled start of their shift or continue working past the regularly scheduled end of their shift to make up any time used for unpaid lactation breaks. Caregivers who wish to do so should speak with the office administrator in advance to make appropriate arrangements.



**JURY DUTY** If a caregiver is called to jury duty, he/she must notify the Coordinator and submit a copy of the Notice to Serve. If a caregiver reports for jury duty and is excused, the Agency requests that he/she return to work to complete his/her regular workday.

If a caregiver does indeed serve as a juror, he/she should submit proof of service. The Agency will then reimburse the first $72 of such juror`s daily wages during the first three days of jury service. Please note: You must be on a current case to be eligible for Jury Duty Compensation.

## MILITARY LEAVE



Caregivers who are required to fulfill military obligations in any branch of the Armed Forces of the United States or in State military service will be given the necessary time off and reinstated in accordance with federal and state law. The time off will be unpaid, except where state or federal law dictates otherwise. Accrued paid time off may be used for this leave.

Military orders should be presented to the Coordinator and arrangements for leave made as early as possible before departure.

You must notify your Coordinator of your intent to return to employment based on requirements of the law. Your benefits may continue to accrue during the period of leave in accordance with state and federal law.

# LEAVE

## TIME OFF TO VOTE



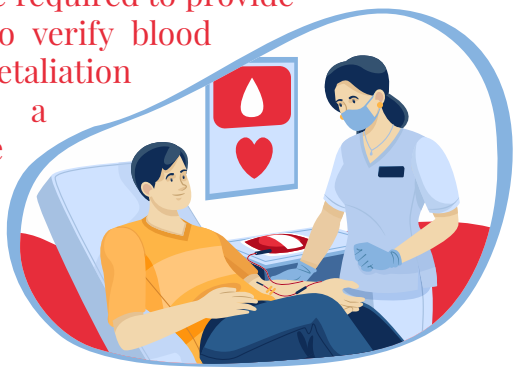

If an employee does not have 4 hours before or after their work shift from when the poll open or closes to vote, an employee is allowed to take 2 hours paid leave to vote.

Employees must give notice to their employer no later than 2 days before the election of their need for the 2 hours paid leave.

## LEAVE FOR BLOOD DONATION

Unless otherwise required by applicable law, upon request, caregivers working 20 or more hours per week on average will be given three (3) hours of unpaid time off in each 12-month period to donate blood. Caregivers must obtain approval from their Coordinator prior to scheduling an appointment to donate blood. The Agency may, due to business necessity, deny a request for a particular leave time and require that the leave be taken at a more appropriate time.

Caregivers will be required to provide documentation to verify blood donation leave. Retaliation for requesting a leave of absence for purposes of donating blood is prohibited.



## LEAVE FOR BONE MARROW DONATION

**Unless** otherwise required by applicable law, upon request, eligible caregiver will be given unpaid leaves of absence to undergo a medical procedure to donate bone marrow. The combined length of the leaves will be as determined by the physician conducting the procedure, but may not exceed twenty-four work hours, unless otherwise agreed by the Agency.

**Caregivers** will be required to provide documentation from the physician conducting the procedure to verify the need for and length of bone marrow donation leave. Retaliation for requesting a leave of absence for purposes of donating bone marrow is prohibited.



## RESIGNATION

**If you resign from your employment with the Agency, you are expected to give a minimum of two (2) weeks notice. To submit a time-off request or resignation from a case, please submit your request with at least two weeks' notice.**

# PRECAUTIONS
## UNIVERSAL / STANDARD

**HANDWASHING –** *some examples include:*



- Upon entering a patient's home
- When hands are soiled
- Between handling individual patients
- Before contact with the face and mouth of the patient
- After personal use of the bathroom
- After changing or assisting with patient's personal needs/bathroom
- Before preparing meals and after preparing meals
- After housekeeping duties are preformed
- Before and after donning gloves

**USE OF PPE –** *Personal Protective Equipment:*

PPE is available for all caregivers. Contact your coordinator for details. PPE includes face masks, gloves, respirator masks, gowns, and eye shields. The agency provides hand sanitizer and disinfectants as needed to ensure the safety of the caregivers.

# RESPIRATORY HYGIENE

## CONTACT PRECAUTION & COVID-19



Our agency monitors reports of the coronavirus. Our agency follows the guidance provided by the Centers for Disease Control and Prevention (CDC) and the State Departments of Health and Centers for Medicare and Medicaid Services (CMS) to ensure that our caregivers are protected. The COVID-19 policy and process are followed and updated as needed.

***ALL CAREGIVERS MUST COMPLETE THEIR DAILY SCREENING BEFORE REPORTING TO WORK.*** If the caregiver should develop any signs of COVID-19 or exposure, on or off work hours, they must isolate and report to their coordinator.

***ALL CAREGIVERS ARE REQUIRED TO WEAR A MASK DURING THE SHIFT AND WHILE IN THE CLIENT'S HOME, REGARDLESS OF THE CAREGIVER'S VACCINATION STATUS.***

**PREVENTION AND PROTECTION ARE CRUCIAL TO OUR AGENCY. HERE ARE A FEW WAYS TO STAY HEALTHY ACCORDING TO THE CDC:**

Wash your hands.

Avoid close contact with people who are sick with symptoms or have been exposed to the virus.

Stay home when you are sick or are being tested for Covid-19.

Avoid touching your eyes, nose, and mouth.

Cover your cough or sneeze with a tissue, then throw the tissue in the trash.

Follow the PPE guidelines and infection control policies.

Receive COVID vaccines and boosters.

Receive your flu vaccine during flu season.

Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.

Avoid congregate settings (crowded public places where close contact with others may occur. Examples include shopping centers, movie theaters, stadiums).

Practice social distancing by remaining out of congregate settings, avoiding mass gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

Follow NY state travel guidance.

# CLEANING AND DISINFECTING ENVIRONMENTAL SURFACES

## CONTACT PRECAUTION & COVID-19

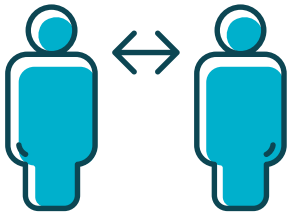
Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom, before eating, and after blowing your nose, coughing, and sneezing. CDC hand washing protocol. Always wash your hands with soap and water if hands are visibly dirty.



If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.

Follow CDC's recommendations for using a face mask:

**The CDC recommends wearing face coverings and eye protection in public settings where social distancing measures are difficult to maintain (e.g., grocery stores and pharmacies). Social distancing is especially important in areas of significant community-based transmission.**



All needed PPE, hand sanitizer, and disinfectant wipes will be available:

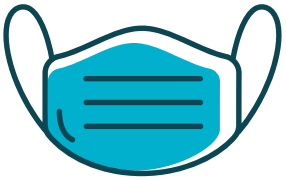
**Patients receive PPE from the MLTC**

**Office staff, field staff, and consultants receive PPE from the agency**

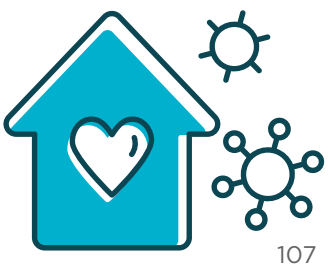


CALL YOUR COORDINATOR OR THE AGENCY WITH ANY CONCERNS REGARDING

**COVID-19 EXPOSURES**







# SHARPS PRECAUTIONS

## PREVENTION FROM NEEDLE STICK INJURIES

If your patient uses any injectable medication, they should be disposed of in a puncture proof container with a tight-fitting screw top. Please notify the Agency if you notice syringes being disposed of improperly.

If your patient uses any injectable medication, please shake out any bed linens/laundry carefully to avoid accidental needle stick from careless handling by patient/family/nurse.

If you get stuck by a needle stick it must be reported to your Coordinator or Human Resources Representative immediately, latest before the end of the shift, to ensure proper medical intervention is provided to you.

## INFECTIOUS DISEASE

If you believe or know you were exposed to disease carrying organisms, immediately and thoroughly wash your hands or other exposed area. If eyes were splashed, rinse thoroughly with clear water only. Call the Agency right after the incident.

You must notify the agency if you have any open, draining wounds (sores), a rash or any other potentially contagious condition. Until this condition improves, you cannot perform direct personal care or handle the patient's equipment.

If you contract any illnesses call your coordinator to discuss your assignment.

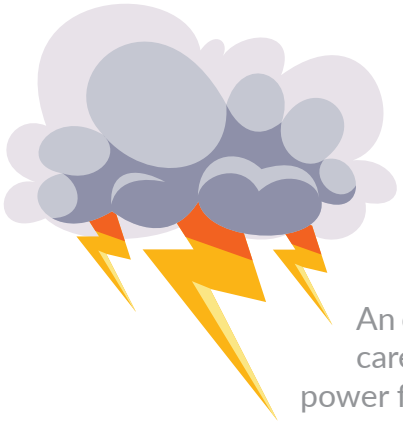
## ON-THE-JOB INJURIES

If you are injured on the job, you are required to call your Coordinator immediately and explain that you have to complete a report related to a workplace injury. You must then complete the report and submit it in a timely fashion. These requirements apply no matter how slight or minor the injury might seem. If you have questions about whether the injury is reportable, still call your Coordinator and ask – do not make these decisions on your own.

Your failure to follow this procedure may result in the appropriate workers' compensation report not being filed in accordance with the law, which may consequently jeopardize your right to benefits. In addition, if we learn that you did not timely report an injury that was sustained or aggravated on the job, you may be terminated for violating this policy which requires timely filing of a claim.

# DISASTER

## EMERGENCY PREPAREDNESS



An occurrence/situation can impact our ability to provide services and care to our patients. Examples of an emergency may be a snowstorm, power failure, hurricane or a transit strike.

In the event of an emergency, **caregiver cooperation and understanding is needed**. We may need to change your case assignment (re-assign you to a case closer to your residence location or to a case of greater risk status- based on the classification system defined in the policy). We may need to ask you to work more hours for which you will be paid or to ask you to work different days, etc.

We expect that all our caregivers will understand the strong need to be available during an emergency. We request that all caregivers will call in to their Coordinator to offer help even when you are not scheduled to work.

The following procedure will be followed: ***the Field Nurse assigns a status to each patient based on Agency criteria (nature of illness, family backup, etc.).*** When an emergency arises:

**Broadway Home Care Coordinators inform patients that we will be implementing our Emergency Disaster Plan**

**Coordinators begin calling caregivers to rearrange assignments in an effort to provide care according to patient Care status**

**Calls are placed to caregivers in an effort to ascertain who is available. Caregivers are expected to call Broadway Home Care as well**



# EMERGENCY MEASURES AND PROCEDURES

Experts agree that people who prepare for emergencies cope better during the crisis and recover more quickly. The best way to reduce risk is to think ahead. The caregiver can assist the patient and family to prepare for possible emergencies.

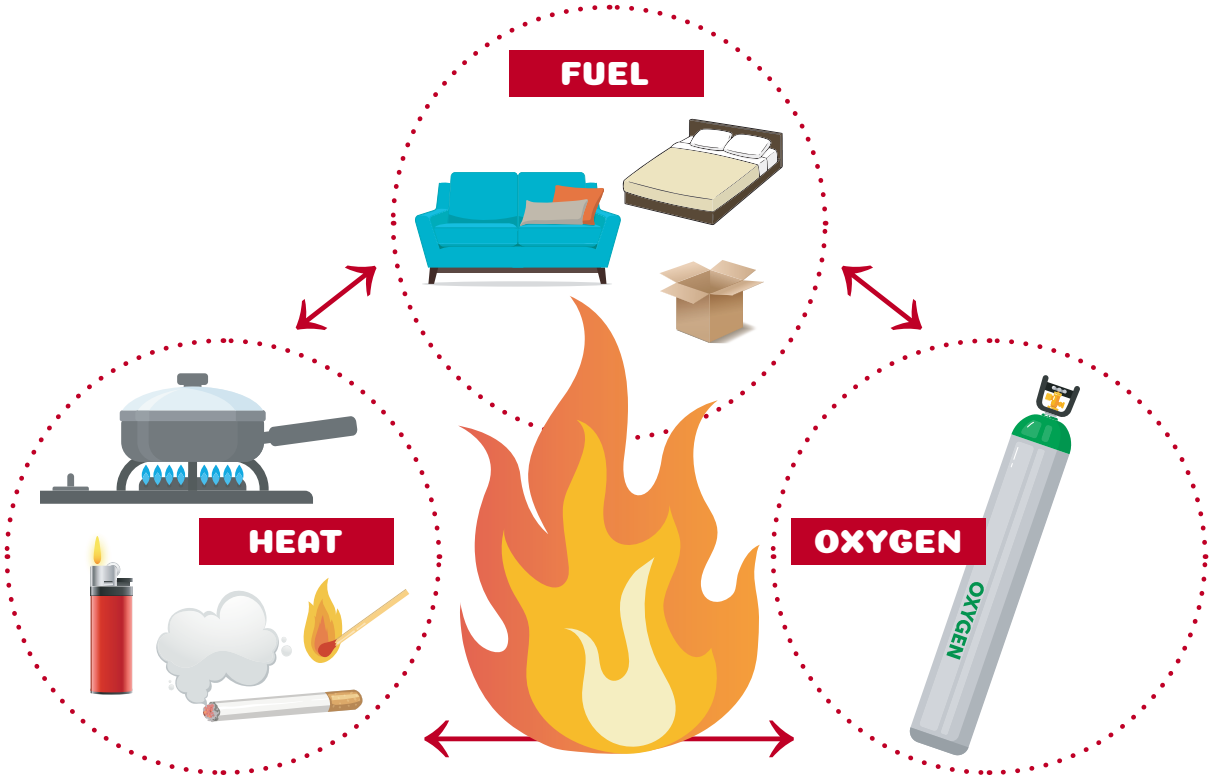
## FIRE

Some causes of fire include the following:

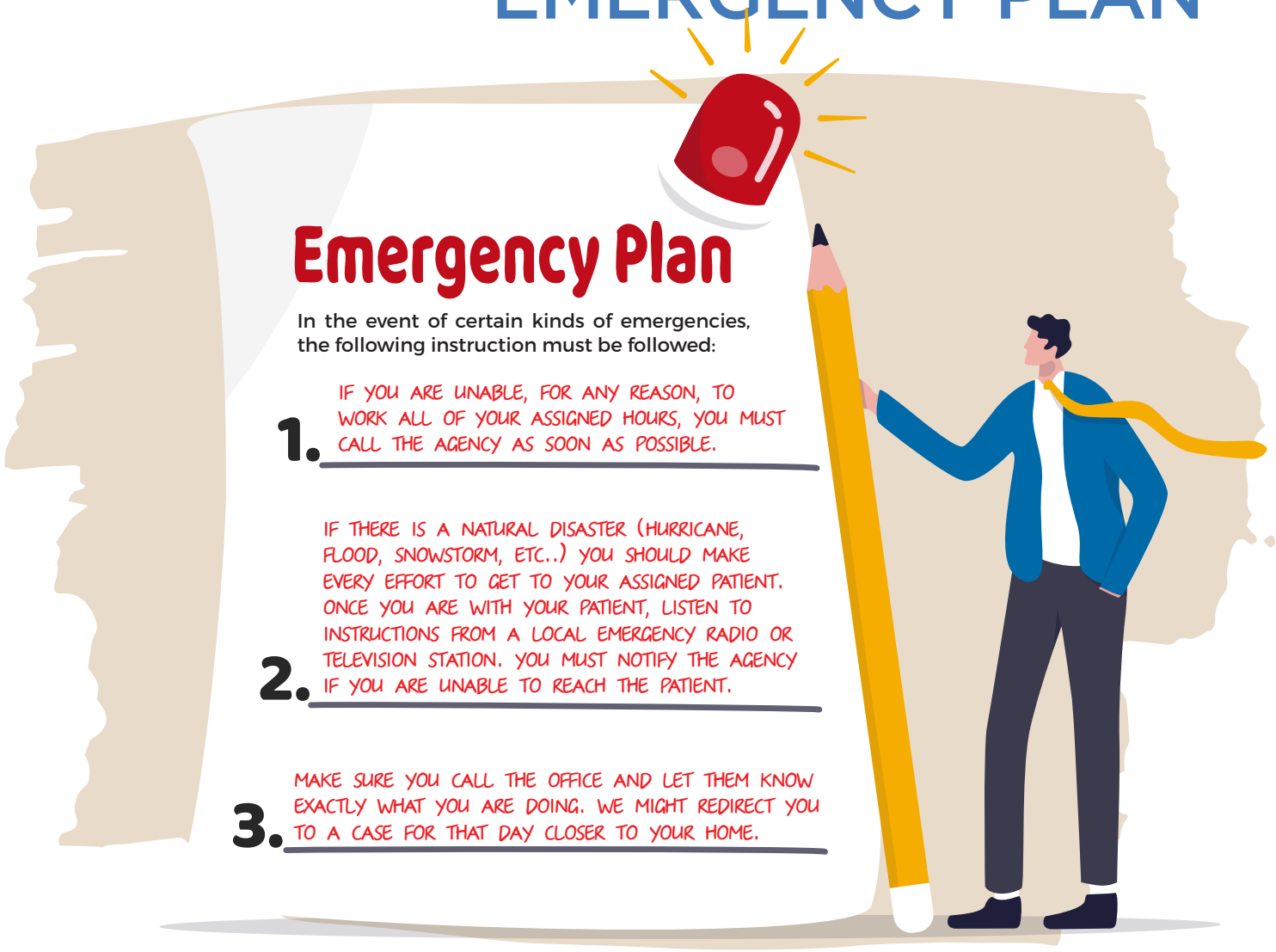
- **Smoking and matches**
- **Unattended lighted candles**
- **Misuse of electricity**
- **Defects in heating system**
- **Materials that ignite easily**
- **Improper trash disposal**
- **Improper cooking techniques**
- **Improper ventilation**
- **Improper use of aerosol cans** *(hair spray, cleaning fluids, paints, etc)*

**IT TAKES 3 THINGS TO START A FIRE:**

1. **FUEL**
   ANY MATERIAL THAT WILL BURN
2. **SOURCE OF HEAT**
   MATCHES, FLAME, SPART
3. **SUPPLY OF OXYGEN**
   PRESENT IN THE AIR



# EMERGENCY PLAN



## Emergency Plan

In the event of certain kinds of emergencies, the following instruction must be followed:

1. IF YOU ARE UNABLE, FOR ANY REASON, TO WORK ALL OF YOUR ASSIGNED HOURS, YOU MUST CALL THE AGENCY AS SOON AS POSSIBLE.

2. IF THERE IS A NATURAL DISASTER (HURRICANE, FLOOD, SNOWSTORM, ETC..) YOU SHOULD MAKE EVERY EFFORT TO GET TO YOUR ASSIGNED PATIENT. ONCE YOU ARE WITH YOUR PATIENT, LISTEN TO INSTRUCTIONS FROM A LOCAL EMERGENCY RADIO OR TELEVISION STATION. YOU MUST NOTIFY THE AGENCY IF YOU ARE UNABLE TO REACH THE PATIENT.

3. MAKE SURE YOU CALL THE OFFICE AND LET THEM KNOW EXACTLY WHAT YOU ARE DOING. WE MIGHT REDIRECT YOU TO A CASE FOR THAT DAY CLOSER TO YOUR HOME.

## INCLEMENT WEATHER

The Agency provides patient services even in the event of inclement weather. In the event caregivers have difficulty with transportation due to the weather, they must contact a supervisor to discuss their options as soon as possible before the beginning of their shift.

## FIRE

If you are with a patient and a fire occurs, you should, at the first sign of smoke, go immediately to the safest exit with the patient. Once away from danger, call the fire department. If the patient cannot be moved, close the door of the patient's room and go to the nearest safe telephone. Dial 911 give them the exact address and name of yourself and the patient. Do not attempt to put out the fire yourself. Do not return to the house until the fire department has given you permission to do so. Notify the Agency as soon as you and your patient are out of danger.

## POWER FAILURE

If you are with a patient and there is a power failure, try to keep the patient as warm and comfortable as possible. Inform the agency as soon as possible. If the patient is on life-support equipment be certain to switch to the generator back up. Notify the utility company and contact the Agency as soon as possible. If your patient is in a life-threatening situation, call 911 immediately.

## MEDICAL EMERGENCY

If a medical emergency occurs while you are with a patient, these are the general rules which you should follow:

- Seek emergency help by dialing the number provided on the emergency sheet on the emergency list.
- Keep patient as comfortable as possible.
- Observe the patient and report all symptoms to emergency personnel.
- Notify the Agency of the situation and the outcome.

You are responsible for the safety and wellbeing of your patient during the assigned hours. If for any reason you cannot provide all the hours of service required, you must notify the Agency at once.

# REPORTING EMERGENCIES, ACCIDENTS, AND CHANGES




Reporting emergencies, accidents, and changes in patient condition is a key part of a caregiver's duties. For life-threatening emergencies, call "911" immediately. In the event of a patient's death, expected or unexpected, please record accurately all data regarding the death. Caregivers shall record the exact time and the events that happened. After calling 911, contact the office for further directions.

If there is an accident, you must call the office immediately. You must also contact the office as soon as possible to report any changes in patient condition.

## *Some examples of accidents or changes that you must report to the office are:*

- PATIENT INJURY OR ILLNESS
- THEFT OR ILLEGAL ACTIVITIES IN THE HOME
- INJURY OR ILLNESS TO YOURSELF
- UNUSUAL OR DANGEROUS PATIENT/ FAMILY BEHAVIOR
- ANY OCCURRENCE REQUIRING POLICE OR EMERGENCY SERVICE
- CHANGE IN PATIENT CONDITION
- PATIENT HOSPITALIZATION
- PATIENT ADMITTED TO A NURSING HOME/REHAB
- OUT OF HOME RESPITE/CARE
- STRUCTURAL DAMAGE TO THE PATIENT'S HOME
- PATIENT NON-COMPLIANCE WITH MEDICAL CARE
- UNSANITARY CONDITIONS IN THE PATIENT'S HOME (INSECT, RODENT, ETC.)
- FAILURE OF UNIVERSAL PRECAUTIONS OR AN INCIDENT OF EXPOSURE TO BLOOD, BODILY FLUIDS OR OTHER INFECTIOUS WASTE
- YOUR PATIENT HAS LEFT THEIR HOME

When you call the office, answer all questions thoroughly and follow instructions carefully. The office staff will also need to fill out our special incident report form in addition to your form and documentation. Accordingly, your cooperation with the office staff is essential!

PLEASE SEE THE HEALTH & SAFETY SECTION OF THIS HANDBOOK FOR MORE INFORMATION.

# ACKNOWLEDGMENT

## ACKNOWLEDGMENT OF RECEIPT

I hereby acknowledge receiving a copy of the Agency's Handbook. I have had the opportunity to ask questions about the policies. **As a condition of my employment with the Agency, I agree to comply with all the rules and procedures of the Agency, as stated in this Handbook and any other document that may be issued to me during my employment, including the FAIR AGREEMENT.**

I understand that the Agency has the maximum discretion permitted by law to interpret, administer, add to, change, or delete provisions in this Manual and Handbook at any time.

Additionally, I acknowledge that no promise of job security has heretofore been given to me and that there are no such promises contained in the Handbook since I am employed AT WILL and may resign at any time or be fired from my job at any time, with or without notice and with or without cause.

I, _____, have been informed that anytime during my employment with Broadway Home Care should my name appear on NYS DOH CHRC with legal charges after hire, the agency will take any and all appropriate actions deemed necessary by NYS DOH, including but not limited to, a CHRC Hold status resulting in my immediate removal from direct patient care pending the submission of a determination letter from the court.

_____

Caregiver Name (PRINT)

_____

Caregiver Signature

_____

Date

# ORIENTATION VERIFICATION

I, _____, have attended orientation today with Broadway Home Care. I hereby agree that as an caregiver with Broadway Home Care, I am responsible for understanding and abiding by the policies and procedures set forth in the orientation and in the provided caregiver handbook.

Provided to me was the following, but not limited to:

- ✓ Caregiver Handbook released January 2019
- ✓ HIPAA regulations
- ✓ HIV Confidentiality
- ✓ Infection Control Review
- ✓ Advance Directives/Living Will/DNR
- ✓ Patient Abuse Reporting Law & Caring for the Sensory Impaired Patient
- ✓ Emergency/Disaster Preparedness
- ✓ Caregiver and Home Safety Review
- ✓ General Company Policies, Procedures and Forms
- ✓ Payroll Guidelines
  - › Training on the Use of Timesheets
  - › Training on the Use of Electronic Clock In/Clock Out System
- ✓ Photo Waiver and Release
- ✓ Drug and Alcohol Policy
- ✓ Sleep & Meal Period Policy for Caregivers on Duty for 24 hours or more
- ✓ FMLA and PFL policy
- ✓ Fact-finding and Issue Resolution ("Fair") Program Policy
- ✓ False Claims Act
- ✓ NYC Earned Sick Time Act
- ✓ Health Insurance Information
- ✓ Wage Parity Benefits

I Agree to the above.

Caregiver Signature:_____ Date: _____

Agency Rep Signature:_____ Date: _____

# NEW YORK

## Package Contents:

- NY State Public Employee Safety & Health Act (PESH Act) *PUBLIC
- NY Child Labor Law
- NY Correction Law
- NY State Human Rights Law: Discrimination
- NY Fringe Benefits & Hours Notice
- NY Minimum Wage
- NY Right to Know: Effects & Hazards of Toxic Substances *PUBLIC
- NY Notice of Employee Rights, Protections, & Obligations Under LLS 740
- NY Veteran Benefits and Services
- NY Unemployment Insurance
- Pay Day Notice
- Emergency Phone Numbers
- Federal Employee Polygraph Protection Act (EPPA)
- Federal Know Your Rights: Workplace Discrimination is Illegal
- Federal Family and Medical Leave Act (FMLA)
- Federal Pregnant Workers Fairness Act (PWFA)
- Federal Fair Labor Standards Act (FLSA)
- Federal Job Safety and Health: It's the Law (OSHA)
- Federal Your Rights Under USERRA

## Package Instructions:

1. Print the following PDF files in 8.5 x11 sheets of paper, unless otherwise specified use the color white.
2. The Federal OSHA poster must be printed in an 8 ½ x 14 sheet of paper to be in compliance.
3. Post the printed sheets in a place frequented by employees (i.e. lunch rooms, HR offices, employee lounges).
4. You may also distribute electronic copies of the Labor Law Notices to all relevant workstations in your facility.

ALL IN ONE POSTER COMPANY, INC.
620 E. Walnut Ave, Fullerton CA 92831
P: 714-521-7720 F: 714-521-7728
www.allinoneposters.com
sales@allinoneposters.com




The New York State Public Employee Safety and Health Act of 1980 provides job safety and health protection for workers through the promotion of safe and healthful working conditions throughout the State. Requirements of the Act include the following:

## Employers

Employers must provide employees with a workplace that is:

- free from recognized hazards,
- in compliance with the safety and health standards that apply to the workplace, and
- in compliance with any other regulations issued under the PESH Act by the Commissioner of Labor.

## Employees

Employees must comply with all safety and health standards that apply to their actions on the job. Employees must also comply with any regulations issued under the PESH Act that apply to their job.

## ENFORCEMENT

The New York State Department of Labor administers and enforces the PESH Act. The Commissioner of Labor issues safety and health standards. The Department's Division of Safety and Health (DOSH) has Inspectors and Hygienists who inspect workplaces to make sure they are followingthe PESH Act.

## Inspection

When DOSH staff inspect a workplace, a representative of the employer and a representative approved by the employees must be allowed to help with the inspection. When there is no employee-approved representative, DOSH staff must speak with a fair number of employees about the safety and health conditions in the workplace.

## Order to Comply

If the Department believes an employer has violated the PESH Act, we will issue an order to comply notice to the employer. The order will list dates by which each violation must be fixed. If violations are not fixed by those dates, the employer may be fined. The order to comply must be posted at or near the place of violation, where it can be easily seen. This is to warn employees that a danger may exist.

## Complaint

Any interested person may file a complaint if they believe there are unsafe or unhealthful conditions in a public workplace. This includes:

- An employee
- A representative of an employee
- Groups of employees
- A representative of a group of employees

Make this complaint in writing to the nearest DOSH office or by email to: **Ask.SHNYPESH@labor.ny.gov**

On request, DOSH will not release the names of any employees who file a complaint. The Department of Labor will evaluate each complaint. The Department will notify the person who made the complaint of the results of the investigation.

These complaints may also be made to the United States Department of Labor, Occupational Safety and Health Administration online at: **www.osha.gov**.

## Discrimination

Employees may not be fired or discriminated against in any way for filing safety and health complaints or otherwise exercising their rights under the Act.

If an employee believes that they have been discriminated against, he or she may file a complaint with the nearest DOSH office. File this complaint within 30 days of the discrimination incident.

## Voluntary Activity

The Department of Labor encourages employers and employees to voluntarily:

- reduce workplace hazards, and
- develop and improve safety and health programs in all workplaces.

The Division of Safety and Health can provide free help with identifying and correcting job site hazards. Employers may request this assistance on a voluntary basis by emailing: **Ask.SHNYPESH@labor.ny.gov**.

## Additional information may be obtained from the nearest DOSH District Office below:

**Albany District**
State Office Campus
Bldg. 12, Rm. 158
Albany, NY 12240
Telephone: **(518) 457-5508**

**Binghamton District**
44 Hawley St., Rm. 901
Binghamton, NY 13901
Telephone: **(607) 721-8211**

**Buffalo District**
295 Main Street, Suite 905
Buffalo, New York 14203-2412

**Garden City District**
400 Oak Street
Garden City, NY 11550
Telephone: **(516) 228-3970**

**New York City District**
Shirley A. Chisholm State
Office Building
55 Hanson Place, 12th Floor
Brooklyn, New York 11217-1523
Telephone: **(212) 775-3554**

**Rochester District**
109 S. Union St., Rm. 402
Rochester, NY 14607
Telephone: **(585) 258-8806**

**Syracuse District**
450 South Salina Street
Syracuse, NY 13202
Telephone: **(315) 479-3212**

**Utica District**
207 Genesee Street
Utica, NY 13501
Telephone: **(315) 793-2258**

**White Plains District**
120 Bloomingdale Road
White Plains, NY 10605
Telephone: **(914) 997-9514**

WE ARE YOUR DOL

NEW YORK STATE Department of Labor

**Division of Labor Standards**
**Worker Protection**

# Summary of New York State Child Labor Law, Permitted Working Hours for Minors Under 18 Years of Age

| Age of Minor Girls and Boys | | Industry or Occupation | Maximum | | | Permitted Hours |
|---|---|---|---|---|---|---|
| | | | Daily Hours | Weekly Hours | Days per Week | |
| **Attending School, When school is in session:** | 14 and 15 | All occupations except farm work, newspaper carrier and street trades | 3 hours on school days.<br>8 hours on other days. | 18[1] | 6 | 7 AM to 7 PM |
| | 16 and 17 | All occupations except farm work, newspaper carrier and street trades. | 4 hours on days preceding school days: Monday, Tuesday, Wednesday, Thursday[2].<br>8 hours on: Friday, Saturday, Sunday and Holidays.[4]. | 28[4] | 6[4] | 6 AM to 10 PM[3] |
| **Attending School, When school is not in session** (vacation): | 14 and 15 | All occupations except farm work, newspaper carrier and street trades. | 8 hours | 40 | 6 | 7 AM to 9 PM<br>June 21 to Labor Day |
| | 16 and 17 | All occupations except farm work, newspaper carrier and street trades | 8 hours[4] | 48[4] | 6[4] | 6 AM to Midnight[4] |
| **Not Attending School:** | 16 and 17 | All occupations except farm work, newspaper carrier and street trades | 8 hours[4] | 48[4] | 6[4] | 6 AM to Midnight[4] |
| **Farm Work:** | 12 and 13 | Hand harvest of berries, fruits and vegetables. | 4 hours | ------ | -------- | June 21 to Labor Day, 7 AM to 7 PM.<br>Day after Labor Day to June 20, 9 AM to 4 PM. |
| | 14 to 18 | Any farm work | ---------- | ------ | -------- | ---------- |
| **Newspaper Carriers:** | 11 to 18 | Delivers, or sells and delivers newspapers, shopping papers or periodicals to homes or business places. | 4 hours on school days.<br>5 hours on other days. | ------ | -------- | 5 AM to 7 PM or 30 minutes prior to sunset, whichever is later |
| **Street Trades:** | 14 to 18 | Self-employed work in public places selling newspapers or work as a bootblack | 4 hours on school days.<br>5 hours on other days. | ------ | -------- | 6 AM to 7 PM |

[1] Students 14 and 15 enrolled in an approved work/study program may work 3 hours on a school day, 23 hours in any one-week when school is in session.
[2] Students 16 and 17 enrolled in an approved Cooperative Education Program may work up to 6 hours on a day preceding a school day other than a Sunday or Holiday when school is in session, as long as the hours are in conjunction with the Program.
[3] 6 AM to 10 PM or until midnight with written parental and educational authorities consent on day preceding a school day and until midnight on day preceding a non- school day with written parental consent.
[4] This provision does not apply to minors employed in resort hotels or restaurants in resort areas.

**The Employer must post a schedule of work hours for minors under 18 years old in the establishment.**

**An Employment Certificate (Working Paper)** is required for all employed minors under 18 years old.

**Penalties for Child Labor Laws violations:**

- First violation: maximum $1,000*
- Second violation: maximum $2,000*
- Third or more violations: maximum $3,000*

*If a minor is seriously injured or dies while illegally employed, the penalty is three times the maximum penalty.

Also, Section 14A of the Workers' Compensation Law provides double compensation and death benefits for minors illegally employed.

Note: There are many prohibited occupations for minors in New York State.

**For more information about New York State Child Labor Laws and provisions** please visit the Department of Labor's website at http://www.labor.ny.gov. If you have questions, please send them to one of the offices listed below at:

**New York State Department of Labor, Division of Labor Standards**:

**Albany District**
State Office Campus
Bldg. 12 Room 185A
Albany, NY 12226
(518) 457-2730

**Buffalo District**
295 Main Street
Suite 914
Buffalo, NY 14203
(716) 847-7141

**New York City District**
55 Hanson Place
11th Floor
Brooklyn, NY 11217
(212) 775-3880

**Syracuse District**
333 East Washington Street
Room 121
Syracuse, NY 13202
(315) 428-4057

**Bronx District**
55 Hanson Place
11th Floor
Brooklyn, NY 11217
(212) 775-3719

**Garden City District**
400 Oak Street
Suite 102
Garden City, NY 11530
(516) 794-8195

**Rochester District**
276 Waring Road
Room 104
Rochester, NY 14609
(585) 258-4550

**White Plains District**
120 Bloomingdale Road
White Plains, NY 10605
(914) 997-9521

# NEW YORK CORRECTION LAW
# ARTICLE 23-A

## LICENSURE AND EMPLOYMENT OF PERSONS PREVIOUSLY CONVICTED OF ONE OR MORE CRIMINAL OFFENSES

**Section 750. Definitions.**

**751. Applicability.**

**752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited.**

**753. Factors to be considered concerning a previous criminal conviction; presumption.**

**754. Written statement upon denial of license or employment.**

**755. Enforcement.**

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§**750. Definitions.** For the purposes of this article, the following terms shall have the following meanings:

(1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.

(2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.

(3) "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity, or job in question.

(4) "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.

(5) "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

§**751. Applicability.** The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have with respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

**§752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited.** No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individual's having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of "good moral character" when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:

(1) There is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or

(2) the issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

**§753. Factors to be considered concerning a previous criminal conviction; presumption.** 1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors:

(a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses.

(b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person.

(c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.

(d) The time which has elapsed since the occurrence of the criminal offense or offenses.

(e) The age of the person at the time of occurrence of the criminal offense or offenses.

(f) The seriousness of the offense or offenses.

(g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.

(h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

**§754. Written statement upon denial of license or employment.** At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

**§755. Enforcement.** 1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules.

2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.

NEW YORK STATE | Division of Human Rights

# 1-888-392-3644
# dhr.ny.gov

THIS ESTABLISHMENT IS SUBJECT TO THE NEW YORK STATE HUMAN RIGHTS LAW (EXECUTIVE LAW, ARTICLE 15)

**Discrimination based upon age, race, creed, color, national origin, sexual orientation, military status, sex, pregnancy, gender identity or expression, citizenship or immigration status, disability, domestic violence victim status, familial status, or marital status is prohibited by the New York State Human Rights Law. Sexual harassment or harassment based upon any of these protected classes also is prohibited.**

**ALL EMPLOYERS, EMPLOYMENT AGENCIES, LABOR ORGANIZATIONS AND APPRENTICESHIP TRAINING PROGRAMS**

Also prohibited: discrimination in employment on the basis of Sabbath observance or religious practices; hairstyles associated with race (also applies to all areas listed below); prior arrest or conviction record; predisposing genetic characteristics; pregnancy-related conditions.

Reasonable accommodations for persons with disabilities and pregnancy-related conditions including lactation may be required. A reasonable accommodation is an adjustment to a job or work environment that enables a person with a disability to perform the essential functions of a job in a reasonable manner.

Also covered: domestic workers; interns and nonemployees working in the workplace (for example temp or contract workers) are protected from all discrimination described above.

**RENTAL, LEASE OR SALE OF HOUSING, LAND AND COMMERCIAL SPACE, INCLUDING ACTIVITIES OF REAL ESTATE BROKERS AND SALES PEOPLE**

Also prohibited: discrimination on the basis of lawful source of income (for example housing vouchers, disability benefits, child support); familial status (families with children or being pregnant); prior arrest or sealed conviction; commercial boycotts or blockbusting.

Reasonable accommodations and modifications for persons with disabilities may also be required.

Does not apply to:
(1) rental of an apartment in an owner-occupied two-family house
(2) restrictions of all rooms in a housing accommodation to individuals of the same sex
(3) rental of a room by the occupant of a house or apartment
(4) sale, rental, or lease of accommodations of housing exclusively to persons 55 years of age or older, and the spouse of such persons

**ALL CREDIT TRANSACTIONS INCLUDING FINANCING FOR PURCHASE, MAINTENANCE AND REPAIR OF HOUSING**

**PLACES OF PUBLIC ACCOMMODATION SUCH AS RESTAURANTS, HOTELS, HOSPITALS AND MEDICAL OFFICES, CLUBS, PARKS AND GOVERNMENT OFFICES**

Exception:
Age is not a covered classification relative to public accommodations
Reasonable accommodations for persons with disabilities may also be required.

**EDUCATION INSTITUTIONS**

All public schools and private nonprofit schools, at all education levels, excluding those run by religious organizations; also for-profit colleges, universities, licensed private career schools or certified English as a second language schools.

**ADVERTISING AND APPLICATIONS RELATING TO EMPLOYMENT, REAL ESTATE, PLACES OF PUBLIC ACCOMMODATION AND CREDIT TRANSACTIONS MAY NOT EXPRESS ANY DISCRIMINATION**

ESTE ESTABLECIMIENTO ESTÁ SUJETO A LA LEY DE DERECHOS HUMANOS DEL ESTADO DE NUEVA YORK (LEY EJECUTIVA, SECCIÓN 15)

**La ley de derechos humanos del estado de nueva york prohíbe la discriminación por edad, raza, credo, color, origen nacional, orientación sexual, estatus militar, sexo, embarazo, identidad o expresión de género, ciudadanía o estatus migratorio, discapacidad, estado como víctima de violencia doméstica, estado familiar, o estado civil. También está prohibido el acoso sexual o el acoso por cualquiera de estas clases protegidas.**

**TODOS LOS EMPLEADORES, AGENCIAS DE EMPLEO, ORGANIZACIONES DE TRABAJO Y PROGRAMAS DE CAPACITACIÓN DE APRENDICES**

Asimismo, está prohibida la discriminación en el empleo sobre la base de la observancia del Shabat o prácticas religiosas; peinados asociados con la raza (también se aplica a las áreas enumeradas a continuación) arresto previo o antecedentes penales; las características genéticas predisponentes; las condiciones relacionadas con el embarazo.

Es posible que sea necesario hacer acomodos razonables para personas con discapacidades y condiciones relacionadas con el embarazo incluyendo lactación. Un arreglo razonable es una adaptación a un trabajo o entorno laboral que permita que una persona con discapacidad realice las tareas esenciales de un trabajo de manera razonable.

También están cubiertos: trabajadores domésticos; internos y no empleados cuales trabajan en el lugar de trabajo (por ejemplo trabajadores temporarios o contratantes) están protegidos de toda discriminación descrita arriba.

**ALQUILER, ARRENDAMIENTO O VENTA DE VIVIENDA, TERRENO O ESPACIO COMERCIAL INCLUYENDO ACTIVIDADES DE AGENTE DE BIENES RAICES Y VENDEDORES**

También esta prohibido: la discriminación a base de fuente de ingreso legal (por ejemplo vales, beneficios de discapacidad, manutención de niños); estado familiar (familias con niños o en estado de embarazo); arresto previo o condena sellada; boicot comercial o acoso inmobiliario.

También es posible que sea necesario realizar modificaciones y arreglos razonables para personas con discapacidades.

Excepciones:
(1) alquiler de un apartamento en una casa para dos familias ocupada por el dueño
(2) restricciones de todas las habitaciones en una vivienda para individuos del mismo sexo
(3) alquiler de una habitación por parte del ocupante de una casa o apartamento
(4) venta, alquiler o arrendamiento de alojamiento en una casa exclusivamente a personas mayores de 55 años y al cónyuge de dichas personas

**TODAS TRANSACCIONES CREDITICIAS INCLUYENDO FINANCIAMENTO PARA LA COMPRA, MANTENIMIENTO Y REPARACION DE VIVIENDAS**

**LUGARES DE ALOJAMIENTO PÚBLICO, COMO RESTAURANTES, HOTELES, HOSPITALES Y CONSULTORIOS MÉDICOS, CLUBS, PARQUES Y OFFICINAS DEL GOBIERNO.**

Excepción:
La edad no es una clasificación cubierta respecto a los alojamientos públicos.
Es posible que sea necesario realizar arreglos razonables para personas con discapacidades.

**INSTITUCIONES EDUCATIVAS**

Todas las escuelas publicas y escuelas privadas sin ánimo de lucro, en todos los niveles, excluyendo escuelas dirigidas por organizaciones religiosas; también están cubiertos: escuelas profesionales autorizadas o escuelas certificadas de inglés como segundo idioma.

**PUBLICIDAD Y SOLICITUDES RELACIONADAS CON EL EMPLEO, LOS INMUEBLES, LOS LUGARES DE ALOJAMIENTO PÚBLICO Y LAS TRANSACCIONES CREDITICIAS NO DEBEN EXPRESAR NINGUN ACTO**

Division of Labor Standards
Harriman State Office Campus
Building 12, Albany, NY 12226

WE ARE YOUR DOL

NEW YORK STATE | Department of Labor

www.labor.ny.gov

# Guidelines for Employers:
# Requirements to Notify Employees About Time Off and Work Hours

**Section 195.5 of the New York State Labor Law effective December 12, 1981 provides as follows:**

*"Every employer shall notify his employees in writing or by publicly posting the employer's policy on sick leave, vacation, personal leave, holidays and hours."*

**To assist employers in complying with this provision, the Division of Labor Standards has issued the following guidelines:**

1. An employer shall distribute in writing to each employee, the employer's policy on the above- enumerated items. The employer upon the request of the Department must be able to affirmatively demonstrate that such written notification was provided to employees by means, which may include, but not be limited to, distribution through company newspapers or newsletters or by inclusion in a company payroll.

   *Or*

   An employer shall post and keep posted in each establishment in a conspicuous place where notices to employees are customarily posted, a notice that states where on the employer's premises they may see such information in writing. Such information may be contained in a union contract, employee handbook, personnel manual, or in other written form. Deviations for an employee from such stated policy must be given to said employee in writing.

2. As used in the provision above, "hours" means the hours which constitute a standard workday and workweek for the establishment, and any other regular schedule, such as for part-time employees. Deviations should be given to the affected employee in writing.

For more information, call or write the nearest office of the Division of Labor Standards, of the New York State Department of Labor, listed below:

**Albany District**
State Office Campus
Bldg. 12 Room 185A
Albany, NY 12226
(518) 457-2730

**Bronx District**
55 Hanson Place
11th Floor
Brooklyn, NY 11217
(212) 775-3719

**New York City District**
55 Hanson Place
11th Floor
Brooklyn, NY 11217
(212) 775-3880

**Garden City District**
400 Oak Street
Suite 102
Garden City, NY 11530
(516) 794-8195

**Buffalo District**
290 Main Street
Room 226
Buffalo, NY 14202
(716) 847-7141

**Rochester District**
276 Waring Road
Room 104
Rochester, NY 14609
(585) 258-4550

**Syracuse District**
333 East Washington Street
Room 121
Syracuse, NY 13202
(315) 428-4057

**White Plains District**
120 Bloomingdale Road
White Plains, NY 10605
(914) 997-9521

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NEW YORK STATE | Department of Labor

# Attention Miscellaneous Industry Employees

Minimum Wage hourly rates effective 1/1/2024 – 12/31/2024

## New York City

| Large Employers (**11 or more** employees) | | Small Employers (**10 or less** employees) | |
|---|---|---|---|
| **Minimum Wage** | **$16.00** | **Minimum Wage** | **$16.00** |
| Overtime after 40 hours | $24.00 | Overtime after 40 hours | $24.00 |
| **Tipped workers** | **$16.00** | **Tipped workers** | **$16.00** |
| Overtime after 40 hours | $24.00 | Overtime after 40 hours | $24.00 |

## Long Island and Westchester County

| | |
|---|---|
| **Minimum Wage** | **$16.00** |
| Overtime after 40 hours | $24.00 |
| **Tipped workers** | **$16.00** |
| Overtime after 40 hours | $24.00 |

## Remainder of New York State

| | |
|---|---|
| **Minimum Wage** | **$15.00** |
| Overtime after 40 hours | $22.50 |
| **Tipped workers** | **$15.00** |
| Overtime after 40 hours | $22.50 |

If you have questions, need more information or want to file a complaint, please visit www.labor.ny.gov/minimumwage or call: **1-888-469-7365**.

**Credits and Allowances** that may reduce your pay below the minimum wage rates shown above:

- **Tips** – Beginning December 31, 2020, your employer must pay the full applicable minimum wage rate, and cannot take any tip credit.
- **Meals and lodging** – Your employer may claim a limited amount of your wages for meals and lodging that they provide to you, as long as they do not charge you anything else. The rates and requirements are set forth in wage orders and summaries, which are available online.

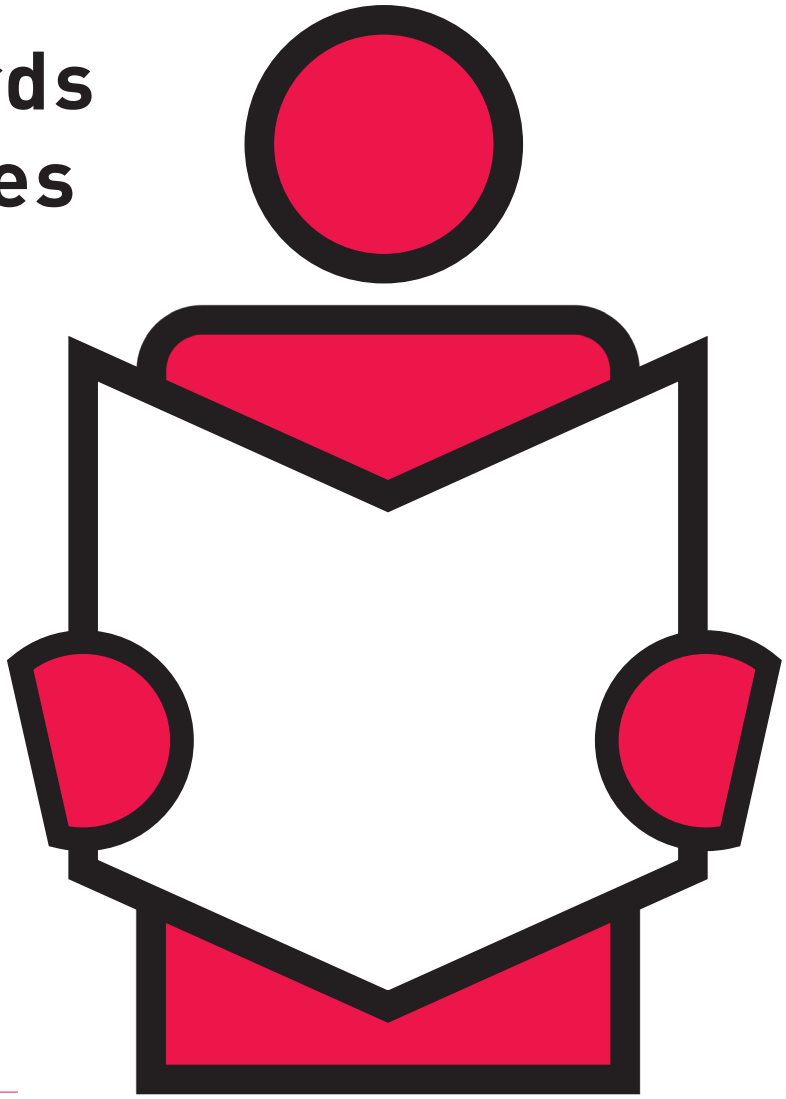
**Extra Pay** you may be owed in addition to the minimum wage rates shown above:

- **Overtime** – You must be paid 1½ times your regular rate of pay (no less than amounts shown above) for weekly hours over 40 (or 44 for residential employees).

  *Exceptions*: Overtime is not required for salaried professionals, or for executives and administrative staff whose weekly salary is more than 75 times the minimum wage rate.
- **Call-in pay** – If you go to work as scheduled and your employer sends you home early, you may be entitled to extra hours of pay at the minimum wage rate for that day.
- **Spread of hours** – If your workday lasts longer than ten hours, you may be entitled to extra daily pay. The daily rate is equal to one hour of pay at the minimum wage rate.
- **Uniform maintenance** – If you clean your own uniform, you may be entitled to additional weekly pay. The weekly rates are available online.

# YOU HAVE A RIGHT TO KNOW!

**Your employer must inform you of the health effects and hazards of toxic substances at your worksite.**



**Learn all you can about toxic substances on your job.**

**For more information, contact:**

Name

Location & Phone Number

**THE RIGHT TO KNOW LAW WORKS FOR YOU.**

NEW YORK STATE DEPARTMENT OF HEALTH

Division of Labor Standards
Harriman State Office Campus
Building 12, Albany, NY 12226

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# Notice of Employee Rights, Protections, and Obligations Under Labor Law Section 740

## Prohibited Retaliatory Personnel Action by Employers
## Effective January 26, 2022

§ 740. Retaliatory action by employers; prohibition.

1. Definitions. For purposes of this section, unless the context specifically indicates otherwise:

(a) "Employee" means an individual who performs services for and under the control and direction of an employer for wages or other remuneration, including former employees, or natural persons employed as independent contractors to carry out work in furtherance of an employer's business enterprise who are not themselves employers.

(b) "Employer" means any person, firm, partnership, institution, corporation, or association that employs one or more employees.

(c) "Law, rule or regulation" includes: (i) any duly enacted federal, state or local statute or ordinance or executive order; (ii) any rule or regulation promulgated pursuant to such statute or ordinance or executive order; or (iii) any judicial or administrative decision, ruling or order.

(d) "Public body" includes the following:

(i) the United States Congress, any state legislature, or any elected local governmental body, or any member or employee thereof;

(ii) any federal, state, or local court, or any member or employee thereof, or any grand or petit jury;

(iii) any federal, state, or local regulatory, administrative, or public agency or authority, or instrumentality thereof;

(iv) any federal, state, or local law enforcement agency, prosecutorial office, or police or peace officer;

(v) any federal, state or local department of an executive branch of government; or

(vi) any division, board, bureau, office, committee, or commission of any of the public bodies described in subparagraphs (i) through (v) of this paragraph.

(e) "Retaliatory action" means an adverse action taken by an employer or his or her agent to discharge, threaten, penalize, or in any other manner discriminate against any employee or former employee exercising his or her rights under this section, including (i) adverse employment actions or threats to take such adverse employment actions against an employee in the terms of conditions of employment including but not limited to discharge, suspension, or demotion; (ii) actions or threats to take such actions that would adversely impact a former employee's current or future employment; or (iii) threatening to contact or contacting United States immigration authorities or otherwise reporting or threatening to report an employee's suspected citizenship or immigration status or the suspected citizenship or immigration status of an employee's family or household member, as defined in subdivision two of section four hundred fifty-nine-a of the social services law, to a federal, state, or local agency.

(f) “Supervisor” means any individual within an employer’s organization who has the authority to direct and control the work performance of the affected employee; or who has managerial authority to take corrective action regarding the violation of the law, rule or regulation of which the employee complains.

2. Prohibitions. An employer shall not take any retaliatory action against an employee, whether or not within the scope of the employee’s job duties, because such employee does any of the following:

(a) discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety;

(b) provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such activity, policy or practice by such employer; or

(c) objects to, or refuses to participate in any such activity, policy or practice.

3. Application. The protection against retaliatory action provided by paragraph (a) of subdivision two of this section pertaining to disclosure to a public body shall not apply to an employee who makes such disclosure to a public body unless the employee has made a good faith effort to notify his or her employer by bringing the activity, policy or practice to the attention of a supervisor of the employer and has afforded such employer a reasonable opportunity to correct such activity, policy or practice. Such employer notification shall not be required where:

(a) there is an imminent and serious danger to the public health or safety;

(b) the employee reasonably believes that reporting to the supervisor would result in a destruction of evidence or other concealment of the activity, policy or practice;

(c) such activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor;

(d) the employee reasonably believes that reporting to the supervisor would result in physical harm to the employee or any other person; or

(e) the employee reasonably believes that the supervisor is already aware of the activity, policy or practice and will not correct such activity, policy or practice.

4. Violation; remedy.

(a) An employee who has been the subject of a retaliatory action in violation of this section may institute a civil action in a court of competent jurisdiction for relief as set forth in subdivision five of this section within two years after the alleged retaliatory action was taken.

(b) Any action authorized by this section may be brought in the county in which the alleged retaliatory action occurred, in the county in which the complainant resides, or in the county in which the employer has its principal place of business. In any such action, the parties shall be entitled to a jury trial.

(c) It shall be a defense to any action brought pursuant to this section that the retaliatory action was predicated upon grounds other than the employee’s exercise of any rights protected by this section.

5. Relief. In any action brought pursuant to subdivision four of this section, the court may order relief as follows:

(a) an injunction to restrain continued violation of this section;

(b) the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or front pay in lieu thereof;

(c) the reinstatement of full fringe benefits and seniority rights;

(d) the compensation for lost wages, benefits and other remuneration;

(e) the payment by the employer of reasonable costs, disbursements, and attorney's fees;

(f) a civil penalty of an amount not to exceed ten thousand dollars; and/or

(g) the payment by the employer of punitive damages, if the violation was willful, malicious or wanton.

6. Employer relief. A court, in its discretion, may also order that reasonable attorneys' fees and court costs and disbursements be awarded to an employer if the court determines that an action brought by an employee under this section was without basis in law or in fact.

7. Existing rights. Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any other law or regulation or under any collective bargaining agreement or employment contract.

8. Publication. Every employer shall inform employees of their protections, rights and obligations under this section, by posting a notice thereof. Such notices shall be posted conspicuously in easily accessible and well-lighted places customarily frequented by employees and applicants for employment.

# VETERAN BENEFITS AND SERVICES

The following resources and hotlines are available at no-cost to help veterans understand their rights, protections, benefits, and accommodations:

**dol.ny.gov/veteran-benefits-and-services**

## MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCES

*All calls and texts are free and confidential*

**U.S. Department of Veterans Affairs Veterans Crisis Line:** www.veteranscrisisline.net

Call: 988, press 1 Text: 838255

**Suicide and Crisis Lifeline:** www.veteranscrisisline.net

Call: 988 Text: 988

**Crisis Textline:**

Text: 741741 Chat: crisistextline.org

**NYS Office of Mental Health (OMH):** www.omh.ny.gov

**NYS Office of Addiction Services and Supports (OASAS):** www.oasas.ny.gov/hopeline

Call: 1-877-8-HOPENY (467469)

Text: HOPENY (467369)

## LEGAL SERVICES

**Veterans Treatment Courts (VTC):** ww2.nycourts.gov/courts/problem_solving/vet/courts.shtml

Email: ProblemSolving@courts.state.ny.us

**NYS Defenders Association Veteran Defense Program:** www.nysda.org/page/AboutVDP

## TAX BENEFITS

**NYS Department of Tax and Finance**

- Information for military personnel and veterans: tax.ny.gov/pit/file/military_page.htm
- Property tax exemptions: tax.ny.gov/pit/property/exemption/vetexempt.htm

## EDUCATION, WORKFORCE, AND TRAINING RESOURCES

**Veteran Readiness and Employment (VR&E) Program:** www.benefits.va.gov/vocrehab

**New York State Civil Service Credits for Veterans Program: www.cs.ny.gov**

## ADDITIONAL RESOURCES

**NYS Domestic and Sexual Violence Hotline:**

Call: 800-942-6906 Text: 844-997-2121

**NYS Workplace Sexual Harassment Hotline:**

Call: 1-800-HARASS-3

**NYS Department of Motor Vehicles:**

- Veteran Status Designation Photo Document: **dmv.ny.gov/more-info/veteran-status-designation-photo-document**
- Veteran License Plate: **dmv.ny.gov/plates/military-and-veterans**

## NEW YORK STATE DEPARTMENT OF VETERANS' SERVICES

Website: **veterans.ny.gov**
Help Line: 1-888-838-7697
Email: DVSInfo@veterans.ny.gov

*Services:* Legal, education, employment and volunteer, financial, health care, and more.

## NEW YORK STATE DEPARTMENT OF LABOR VETERANS' PROGRAM

Website: **dol.ny.gov/services-veterans**
Help Line: 1-888-469-7365
Email: Ask.Vets@labor.ny.gov

*Services:* Workforce and training resources, unemployment insurance, the Experience Counts program, and more.

NEW YORK STATE | Department of Veterans' Services

WE ARE YOUR DOL

NEW YORK STATE | Department of Labor



The New York State Department of Labor is an Equal Opportunity Employer/Program.
Auxiliary aides and services are available upon request and free of charge to individuals with disabilities TTY/TDD 711 or 1-800-662-1220 (English) / 1-877-662-4886.

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NEW YORK STATE | Department of Labor

**Unemployment Insurance**
Division

# Notice to Employees

**Employer Legal Name:** _____

**Address:** _____

**Employer Registration (ER) #:** _____

**Employees of this firm: you are covered by the New York State Unemployment Insurance Law.**

- Your employer may not deduct from your wages for this purpose.

- **If you are laid off, work less than four days a week, or resign:**
  - **Get a "Record of Employment," form from your employer. Keep it for your records to use if you file for Unemployment Insurance benefits.**
  - The "Record of Employment" form must have your employer's name, registration number, and address where payroll records are kept.
- **To file an application for Unemployment Insurance:**
  - Call the Telephone Claims Center at (888) 209-8124 (translation services are available) or
  - Go to our website at www.labor.ny.gov
  - Hearing impaired individuals who have telephone Device for the Deaf (TTY/TDD) equipment may file a claim by calling a relay operator at (800) 662-1220 and requesting the operator call (888) 783-1370. Service at this number is provided only to callers using TDD equipment.

**To Employer: You must post this poster conspicuously in each workplace.**

Employers who utilize the fill-in version of this poster certify to the completeness and accuracy of the legal name, address and Employer Registration # displayed. For additional posters, write to the: New York State Department of Labor, Liability and Determination Section, Harriman State Office Campus, Albany, NY 12226.

IA 133 (04/23) Equal Opportunity Employer/Program – Auxiliary aids and services are available upon request to individuals with disabilities.

# PAY DAY NOTICE

Regular Pay Days for Employees of _____

(Firm Name)

shall be as follows:

☐ Weekly ☐ Bi-Weekly ☐ Semi Monthly ☐ Monthly

Pay Checks will be distributed at

_____

(Place of Distribution)

**This is in accordance with New York State Law**

By _____ Title _____

# EMERGENCY PHONE NUMBERS

## For

_____

(Please Give Exact address of This Worksite Location)

**Physicians:** _____

**Hospitals:** _____

**Ambulances: 911 or** _____

**Fire Department 911 or:** _____

**Police: 911 or** _____

**PLEASE POST IN A CONSPICUOUS LOCATION**

# EMPLOYEE RIGHTS

## EMPLOYEE POLYGRAPH PROTECTION ACT

**The Employee Polygraph Protection Act prohibits most private employers from using lie detector tests either for pre-employment screening or during the course of employment.**

**PROHIBITIONS**

Employers are generally prohibited from requiring or requesting any employee or job applicant to take a lie detector test, and from discharging, disciplining, or discriminating against an employee or prospective employee for refusing to take a test or for exercising other rights under the Act.

**EXEMPTIONS**

Federal, State and local governments are not affected by the law. Also, the law does not apply to tests given by the Federal Government to certain private individuals engaged in national security-related activities.

The Act permits polygraph (a kind of lie detector) tests to be administered in the private sector, subject to restrictions, to certain prospective employees of security service firms (armored car, alarm, and guard), and of pharmaceutical manufacturers, distributors and dispensers.

The Act also permits polygraph testing, subject to restrictions, of certain employees of private firms who are reasonably suspected of involvement in a workplace incident (theft, embezzlement, etc.) that resulted in economic loss to the employer.

The law does not preempt any provision of any State or local law or any collective bargaining agreement which is more restrictive with respect to lie detector tests.

**EXAMINEE RIGHTS**

Where polygraph tests are permitted, they are subject to numerous strict standards concerning the conduct and length of the test. Examinees have a number of specific rights, including the right to a written notice before testing, the right to refuse or discontinue a test, and the right not to have test results disclosed to unauthorized persons.

**ENFORCEMENT**

The Secretary of Labor may bring court actions to restrain violations and assess civil penalties against violators. Employees or job applicants may also bring their own court actions.

**THE LAW REQUIRES EMPLOYERS TO DISPLAY THIS POSTER WHERE EMPLOYEES AND JOB APPLICANTS CAN READILY SEE IT.**

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

1-866-487-9243
www.dol.gov/agencies/whd

WH1462 REV 02/22

# Know Your Rights:
# Workplace Discrimination is Illegal

**The U.S. Equal Employment Opportunity Commission (EEOC) enforces Federal laws that protect you from discrimination in employment. If you believe you've been discriminated against at work or in applying for a job, the EEOC may be able to help.**

## Who is Protected?

- Employees (current and former), including managers and temporary employees
- Job applicants
- Union members and applicants for membership in a union

## What Organizations are Covered?

- Most private employers
- State and local governments (as employers)
- Educational institutions (as employers)
- Unions
- Staffing agencies

## What Types of Employment Discrimination are Illegal?

Under the EEOC's laws, an employer may not discriminate against you, regardless of your immigration status, on the bases of:

- Race
- Color
- Religion
- National origin
- Sex (including pregnancy, childbirth, and related medical conditions, sexual orientation, or gender identity)
- Age (40 and older)
- Disability
- Genetic information (including employer requests for, or purchase, use, or disclosure of genetic tests, genetic services, or family medical history)
- Retaliation for filing a charge, reasonably opposing discrimination, or participating in a discrimination lawsuit, investigation, or proceeding
- Interference, coercion, or threats related to exercising rights regarding disability discrimination or pregnancy accommodation

## What Employment Practices can be Challenged as Discriminatory?

All aspects of employment, including:

- Discharge, firing, or lay-off
- Harassment (including unwelcome verbal or physical conduct)
- Hiring or promotion
- Assignment
- Pay (unequal wages or compensation)
- Failure to provide reasonable accommodation for a disability; pregnancy, childbirth, or related medical condition; or a sincerely-held religious belief, observance or practice
- Benefits
- Job training
- Classification
- Referral
- Obtaining or disclosing genetic information of employees
- Requesting or disclosing medical information of employees
- Conduct that might reasonably discourage someone from opposing discrimination, filing a charge, or participating in an investigation or proceeding
- Conduct that coerces, intimidates, threatens, or interferes with someone exercising their rights, or someone assisting or encouraging someone else to exercise rights, regarding disability discrimination (including accommodation) or pregnancy accommodation

## What can You Do if You Believe Discrimination has Occurred?

Contact the EEOC promptly if you suspect discrimination. Do not delay, because there are strict time limits for filing a charge of discrimination (180 or 300 days, depending on where you live/work). You can reach the EEOC in any of the following ways:

**Submit** an inquiry through the EEOC's public portal: *https://publicportal.eeoc.gov/Portal/Login.aspx*

**Call** 1–800–669–4000 (toll free)
1–800–669–6820 (TTY)
1–844–234–5122 (ASL video phone)

**Visit** an EEOC field office (information at *www.eeoc.gov/field-office*)

**E-Mail** *info@eeoc.gov*

Additional information about the EEOC, including information about filing a charge of discrimination, is available at *www.eeoc.gov*.

# EMPLOYERS HOLDING FEDERAL CONTRACTS OR SUBCONTRACTS

The Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) enforces the nondiscrimination and affirmative action commitments of companies doing business with the Federal Government. If you are applying for a job with, or are an employee of, a company with a Federal contract or subcontract, you are protected under Federal law from discrimination on the following bases:

## Race, Color, Religion, Sex, Sexual Orientation, Gender Identity, National Origin

Executive Order 11246, as amended, prohibits employment discrimination by Federal contractors based on race, color, religion, sex, sexual orientation, gender identity, or national origin, and requires affirmative action to ensure equality of opportunity in all aspects of employment.

## Asking About, Disclosing, or Discussing Pay

Executive Order 11246, as amended, protects applicants and employees of Federal contractors from discrimination based on inquiring about, disclosing, or discussing their compensation or the compensation of other applicants or employees.

## Disability

Section 503 of the Rehabilitation Act of 1973, as amended, protects qualified individuals with disabilities from discrimination in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment by Federal contractors. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship to the employer. Section 503 also requires that Federal contractors take affirmative action to employ and advance in employment qualified individuals with disabilities at all levels of employment, including the executive level.

## Protected Veteran Status

The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212, prohibits employment discrimination against, and requires affirmative action to recruit, employ, and advance in employment, disabled veterans, recently separated veterans (i.e., within three years of discharge or release from active duty), active duty wartime or campaign badge veterans, or Armed Forces service medal veterans.

## Retaliation

Retaliation is prohibited against a person who files a complaint of discrimination, participates in an OFCCP proceeding, or otherwise opposes discrimination by Federal contractors under these Federal laws.

Any person who believes a contractor has violated its nondiscrimination or affirmative action obligations under OFCCP's authorities should contact immediately:

The Office of Federal Contract Compliance Programs (OFCCP)
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210
1–800–397–6251 (toll-free)

If you are deaf, hard of hearing, or have a speech disability, please dial 7–1–1 to access telecommunications relay services. OFCCP may also be contacted by submitting a question online to OFCCP's Help Desk at *https://ofccphelpdesk.dol.gov/s/*, or by calling an OFCCP regional or district office, listed in most telephone directories under U.S. Government, Department of Labor and on OFCCP's "Contact Us" webpage at *https://www.dol.gov/agencies/ofccp/contact*.

# PROGRAMS OR ACTIVITIES RECEIVING FEDERAL FINANCIAL ASSISTANCE

## Race, Color, National Origin, Sex

In addition to the protections of Title VII of the Civil Rights Act of 1964, as amended, Title VI of the Civil Rights Act of 1964, as amended, prohibits discrimination on the basis of race, color or national origin in programs or activities receiving Federal financial assistance. Employment discrimination is covered by Title VI if the primary objective of the financial assistance is provision of employment, or where employment discrimination causes or may cause discrimination in providing services under such programs. Title IX of the Education Amendments of 1972 prohibits employment discrimination on the basis of sex in educational programs or activities which receive Federal financial assistance.

## Individuals with Disabilities

Section 504 of the Rehabilitation Act of 1973, as amended, prohibits employment discrimination on the basis of disability in any program or activity which receives Federal financial assistance. Discrimination is prohibited in all aspects of employment against persons with disabilities who, with or without reasonable accommodation, can perform the essential functions of the job.

If you believe you have been discriminated against in a program of any institution which receives Federal financial assistance, you should immediately contact the Federal agency providing such assistance.

*(Revised 6/27/2023)*

# Your Employee Rights Under the Family and Medical Leave Act

## What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

## Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

## How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

## What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

## Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process.**

**WAGE AND HOUR DIVISION**
UNITED STATES DEPARTMENT OF LABOR

SCAN ME



# PREGNANT WORKERS FAIRNESS ACT (PWFA)

## WHAT IS PWFA?

The Pregnant Workers Fairness Act (PWFA) is a federal law that requires covered employers to provide "reasonable accommodations" to a qualified worker's known limitations related to pregnancy, childbirth, or related medical conditions, unless the accommodation will cause the employer an "undue hardship." An undue hardship is defined as causing significant difficulty or expense.

A **"reasonable accommodation"** means a change in the work environment or how things are usually done in order to remove work-related barriers.

## WHAT ARE SOME POSSIBLE ACCOMMODATIONS FOR PREGNANT WORKERS?

- Schedule changes or time off to go to health care appointments
- Extra bathroom breaks
- A chair or stool to sit on while working
- The ability to telework full or part-time
- A private place to pump breast milk
- Leave to recover from childbirth
- Breaks to eat and drink
- Light duty



## WHAT OTHER FEDERAL EMPLOYMENT LAWS MAY APPLY TO PREGNANT WORKERS?

Other laws that apply to workers affected by pregnancy, childbirth, or related medical conditions, include:



- Title VII of the Civil Rights Act of 1964 which prohibits employment discrimination based on sex, pregnancy, or other protected categories (enforced by the U.S. Equal Employment Opportunity Commission (EEOC))
- The Americans with Disabilities Act (ADA) which prohibits employment discrimination based on disability (enforced by the EEOC)
- The Family and Medical Leave Act which provides unpaid leave for certain workers for pregnancy and to bond with a new child (enforced by the U.S. Department of Labor)
- The PUMP Act which provides nursing mothers a time and private place to pump at work (enforced by the U.S. Department of Labor)

Learn more at www.EEOC.gov/Pregnancy-Discrimination

# EMPLOYEE RIGHTS

## UNDER THE FAIR LABOR STANDARDS ACT

## FEDERAL MINIMUM WAGE

# $7.25 PER HOUR

**BEGINNING JULY 24, 2009**

**The law requires employers to display this poster where employees can readily see it.**

**OVERTIME PAY**

At least 1½ times the regular rate of pay for all hours worked over 40 in a workweek.

**CHILD LABOR**

An employee must be at least 16 years old to work in most non-farm jobs and at least 18 to work in non-farm jobs declared hazardous by the Secretary of Labor. Youths 14 and 15 years old may work outside school hours in various non-manufacturing, non-mining, non-hazardous jobs with certain work hours restrictions. Different rules apply in agricultural employment.

**TIP CREDIT**

Employers of "tipped employees" who meet certain conditions may claim a partial wage credit based on tips received by their employees. Employers must pay tipped employees a cash wage of at least $2.13 per hour if they claim a tip credit against their minimum wage obligation. If an employee's tips combined with the employer's cash wage of at least $2.13 per hour do not equal the minimum hourly wage, the employer must make up the difference.

**PUMP AT WORK**

The FLSA requires employers to provide reasonable break time for a nursing employee to express breast milk for their nursing child for one year after the child's birth each time the employee needs to express breast milk. Employers must provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by the employee to express breast milk.

**ENFORCEMENT**

The Department has authority to recover back wages and an equal amount in liquidated damages in instances of minimum wage, overtime, and other violations. The Department may litigate and/or recommend criminal prosecution. Employers may be assessed civil money penalties for each willful or repeated violation of the minimum wage or overtime pay provisions of the law. Civil money penalties may also be assessed for violations of the FLSA's child labor provisions. Heightened civil money penalties may be assessed for each child labor violation that results in the death or serious injury of any minor employee, and such assessments may be doubled when the violations are determined to be willful or repeated. The law also prohibits retaliating against or discharging workers who file a complaint or participate in any proceeding under the FLSA.

**ADDITIONAL INFORMATION**

- Certain occupations and establishments are exempt from the minimum wage, and/or overtime pay provisions. Certain narrow exemptions also apply to the pump at work requirements.
- Special provisions apply to workers in American Samoa, the Commonwealth of the Northern Mariana Islands, and the Commonwealth of Puerto Rico.
- Some state laws provide greater employee protections; employers must comply with both.
- Some employers incorrectly classify workers as "independent contractors" when they are actually employees under the FLSA. It is important to know the difference between the two because employees (unless exempt) are entitled to the FLSA's minimum wage and overtime pay protections and correctly classified independent contractors are not.
- Certain full-time students, student learners, apprentices, and workers with disabilities may be paid less than the minimum wage under special certificates issued by the Department of Labor.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

1-866-487-9243
www.dol.gov/agencies/whd

WH1088 REV 04/23

U.S. Department of Labor

OSHA®
Occupational Safety and Health Administration

# Job Safety and Health
# IT'S THE LAW!

## All workers have the right to:

- A safe workplace.
- Raise a safety or health concern with your employer or OSHA, or report a work-related injury or illness, without being retaliated against.
- Receive information and training on job hazards, including all hazardous substances in your workplace.
- Request a confidential OSHA inspection of your workplace if you believe there are unsafe or unhealthy conditions. You have the right to have a representative contact OSHA on your behalf.
- Participate (or have your representative participate) in an OSHA inspection and speak in private to the inspector.
- File a complaint with OSHA within 30 days (by phone, online or by mail) if you have been retaliated against for using your rights.
- See any OSHA citations issued to your employer.
- Request copies of your medical records, tests that measure hazards in the workplace, and the workplace injury and illness log.

*This poster is available free from OSHA.*

**Contact OSHA. We can help.**

## Employers must:

- Provide employees a workplace free from recognized hazards. It is illegal to retaliate against an employee for using any of their rights under the law, including raising a health and safety concern with you or with OSHA, or reporting a work-related injury or illness.
- Comply with all applicable OSHA standards.
- Notify OSHA within 8 hours of a workplace fatality or within 24 hours of any work-related inpatient hospitalization, amputation, or loss of an eye.
- Provide required training to all workers in a language and vocabulary they can understand.
- Prominently display this poster in the workplace.
- Post OSHA citations at or near the place of the alleged violations.

On-Site Consultation services are available to small and medium-sized employers, without citation or penalty, through OSHA-supported consultation programs in every state.



**1-800-321-OSHA (6742) • TTY 1-877-889-5627 • www.osha.gov**

OSHA 3165-04R 2019

# YOUR RIGHTS UNDER USERRA

## THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

**USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.**

### REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

### RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

### HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

### ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at https://www.dol.gov/agencies/vets/. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: https://www.dol.gov/agencies/vets/programs/userra/poster Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

**U.S. Department of Labor**
**1-866-487-2365**

**U.S. Department of Justice**

**Office of Special Counsel**

**1-800-336-4590**

Publication Date — May 2022

# BROADWAY HOME CARE, INC.
## Commitment To Compliance

At Broadway Home Care, Inc. ("the Agency"), we strive to earn the trust of our patients and the respect of the communities we serve. To help us do that, we have implemented a Compliance Program and Code of Conduct.

☐ **Who is responsible?** All persons who are affected by the Agency's "risk areas," including our Personnel, nurses, practitioners, employees, supervisors, managers, officers, directors, contractors, agents, subcontractors, independent contractors and entities with which we do business.

☐ **What are the rules that must be followed?** The standards set forth in the Code of Conduct provide an overview of the rules that you are expected to follow. All Personnel are provided with a copy of the Code of Conduct and the Compliance Program Structure and Guidelines. We expect everyone to conduct themselves pursuant to the highest ethical, business, and legal standards. If you suspect that someone is doing anything that is illegal or unethical, you must report it.

☐ **Examples of what needs to be reported:**

- Improper billing practices (e.g., selecting procedure or diagnosis codes on the basis of whether payment will be made rather than on the actual diagnosis or procedure provided; "up-coding;" billing for services not provided, etc.).
- Improper documentation of patient care.
- Giving or accepting something of value in exchange for referrals.
- Improper marketing practices.
- Any activity or business practice that could possibly be interpreted as unethical or illegal.

## How to Report Compliance Violations:

- Contact the Compliance Officer, Kreindy Lobl, at (845) 203-1635 or by email at klobl@elitehc.net.
- Call the "Compliance Hotline" anonymously at (646) 828-8036.
- Online form: https://app.smartsheet.com/b/form/f3abd14295f74b8ab59afbadb5f3f61e

- All reported compliance issues will be investigated.
- You may raise the issue anonymously if you wish. If you report through the Compliance Hotline your identity will be kept confidential unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding.
- Be assured that intimidation or retaliation against anyone who in good faith raises a compliance issue or otherwise participates in the Agency's Compliance Program is strictly prohibited.

# COMPLIANCE MANUAL – HANDBOOK ADDENDUM

## CODE OF CONDUCT
## COMPLIANCE PROGRAM STRUCTURE & GUIDELINES

**Adopted: March 2023 (Post New OMIG Regs 12/2022)**
**Revised: July 2025**

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# Introduction

The Agency has designed and implemented a comprehensive Compliance Program that sets forth the standards of conduct, policies and procedures that all "Affected Individuals" (as defined below) are expected to follow. Our Compliance Program consists of the following:

A. **Compliance Program Code of Conduct.** The Code of Conduct sets forth the general standards of conduct to which all Affected Individuals associated with the Agency must adhere.

B. **Compliance Program Structure and Guidelines.** The Compliance Program Structure and Guidelines set forth the structure of the Compliance Program and describes its day-to-day operation.

   ***All Affected Individuals are required to review and be familiar with the Code of Conduct and the Compliance Program Structure and Guidelines.***

C. **Specific Compliance Policies and Procedures.** Certain compliance issues require further detail and instruction. To that end, the Agency has adopted specific Compliance Policies and Procedures covering certain areas. ***If you have specific responsibilities that are addressed by a Compliance Policy and Procedure, you must ensure that you are familiar with its requirements.*** Compliance Policies and Procedures are available upon request from the Compliance Officer at any time.

The Code of Conduct, the Compliance Program Structure and Guidelines, and our Compliance Policies and Procedures are collectively referred to as the Agency's "Compliance Manual".

The Agency expects to conduct its business in a manner that supports integrity in our operations. To that end, our Compliance Program is designed to effectively prevent, detect and correct non-compliance with applicable laws, rules and regulations, including Federal health care program requirements (*e.g.,* the Medicare and Medicaid programs). Our Compliance Program has many goals. Among them are: (i) detecting and preventing fraud, waste and abuse, (ii) organizing our resources to address compliance issues as quickly and efficiently as possible, and (iii) putting in place a system of checks and balances to prevent recurrence of any such issues.

We require that all Affected Individuals cooperate fully with the Compliance Program.

In short, we are committed to doing the right thing legally and ethically, and our Compliance Program is designed to assist us in effectively keeping to that commitment. Conduct that is contrary to these expectations will be considered a violation of the Compliance Program.

If you have any questions regarding the Compliance Program, please refer to the Code of Conduct, the Compliance Program Structure and Guidelines or Compliance Policies and Procedures or speak with our Compliance Officer for more detailed information.

# Key Definitions

Unless otherwise defined in the Compliance Manual, the terms listed below have the following meanings:

1. "***Compliance Committee***" means the group established by the Agency to coordinate with the Compliance Officer to ensure that the Agency is conducting its business in an ethical and responsible manner, consistent with our Compliance Program.

2. "***Compliance Officer"*** means the individual designated by the Agency with responsibility for the day-to-day operation of the Compliance Program. The Compliance Officer is the focal point for our Compliance Program. *(See compliance poster for updated information)* is the Compliance Officer for the Agency. The Compliance Officer reports directly to, and is accountable to, the Agency's Chief Executive Officer.
3. ***"Federal health care program"*** means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government, including certain State health care programs. Examples include, but are not limited to: Medicare, Medicaid, Veterans' programs and the State Children's Health Insurance Programs. The Federal Employees Health Benefits Program is not included in this definition.

4. **"*Good faith participation in the Compliance Program***" includes, but is not limited to, the following actions when taken in good faith: (a) reporting potential compliance issues to appropriate personnel; (b) participating in investigation of potential compliance issues; (c) self-evaluations; (d) audits; (e) remedial actions; (f) reporting instances of intimidation or retaliation; and (g) reporting potential fraud, waste or abuse to the appropriate State or Federal entities.

5. **"*Affected Individuals*"** means all persons who are affected by the Agency's "risk areas," including our employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers. Affected Individuals are sometimes referred to in this Compliance Manual as "you."

6. ***"Effective compliance program"*** means a compliance program adopted and implemented that, at a minimum, satisfies the requirements of 18 NYCRR Subpart 521-1 and that is designed to be compatible with our characteristics (*i.e.,* our size, complexity, resources, and culture). Our Compliance Program is designed to ensure that it: (i) is well-integrated into our operations and supported by the highest levels of the organization, including the chief executive, senior management, and the governing body; (ii) promotes adherence to our legal and ethical obligations; and (iii) is reasonably designed and implemented to prevent, detect, and correct noncompliance with applicable Federal health care programs (including, but not limited to, Medicare and Medicaid) and other requirements, including fraud, waste, and abuse most likely to occur for the Agency's "risk areas" and "organizational experience."

7. "***Organizational experience"*** means the Agency's: (i) knowledge, skill, agency and understanding in operating our Compliance Program; (ii) identification of any issues or risk areas in the course of our internal monitoring and auditing activities; (iii) experience, knowledge, skill, practice and understanding of our participation in Federal health care programs (including, but

not limited to, Medicare and Medicaid) and the results of any audits, investigations, or reviews we have been the subject of; and (iv) awareness of any issues we should have reasonably become aware of for our category or categories of service.

8. ***"Risk areas"*** are those areas to which the Agency's Compliance Program applies. This includes those areas of operation affected by the Compliance Program and applies to: (i) billings; (ii) payments; (iii) ordered services; (iv) medical necessity; (v) quality of care; (vi) governance; (vii) mandatory reporting; (viii) credentialing; (ix) contractor, subcontractor, agent or independent contract oversight; and (x) other risk areas that are or should reasonably be identified through our organizational experience.

9. ***"Contractors"*** means contractors, agents, subcontractors, and/or independent contractors who are affected by the Agency's risk areas.

# Code of Conduct

This Code of Conduct sets forth the standards of conduct that all Affected Individuals must adhere to and follow.

## I. CODE OF CONDUCT: COMMITMENT TO COMPLIANCE

- The Agency's goal is to provide comprehensive at-home services to enhance our clients and their families' lives. We strive to be home health care leaders in the communities that we serve and will continue to do so by being focused on quality, service, and technology.
- The Agency strives to provide high quality services to our clients without regard to age, race, color, sexual orientation, marital status, religion, sex, or national origin. We have a commitment to conduct our business in compliance with all applicable laws, rules and regulations and in accordance with ethical principles. The Agency expects the same from all Affected Individuals. We do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with the Agency. We will follow the letter and spirit of applicable laws, rules and regulations, conduct our business ethically and honestly, and act in a manner that enhances our standing in the community.

## II. CODE OF CONDUCT: SCOPE OF APPLICATION to AFFECTED INDIVIDUALS

- The Compliance Program - and specifically this Code of Conduct - applies to all Affected Individuals. The term Affected Individuals is defined in this Compliance Manual.
- All Affected Individuals have a responsibility to help create and maintain a work environment in which compliance concerns may be openly raised, and promptly reviewed, discussed and addressed.

## III. CODE OF CONDUCT: STANDARDS

### ☐ General Standards

- You must be honest and lawful in all of your business dealings and avoid doing anything that could create even the appearance of impropriety.
- You must: comply with the Code of Conduct; refuse to participate in any action you think may be possibly unethical, illegal or in violation of the Code of Conduct, a Compliance Policy and Procedure or the Compliance Program; report compliance issues and any unethical or illegal conduct to the Compliance Officer; cooperate with compliance inquiries and investigations; and work to correct any improper practices that are identified. The Agency expects and requires your good faith participation in the Compliance Program.
- Acts of retaliation or intimidation for good faith reporting of any suspected violation of, or for other good faith participation in, the Compliance Program will not be tolerated and are themselves a violation of the Compliance Program. ***For more information,*** see the

Non-Retaliation, Non-Intimidation for Good Faith Participation in the Compliance Program Policy.

☐ **Standards Related to Quality of Care/Credentialing/Medical Necessity**

- You are required to protect and promote the rights of all patients, including but not limited to, the right to participate in all decisions about their own care and treatment.

- You must ensure that patient care conforms to acceptable clinical and safety standards.

- All personal care and home care services provided to our patients are furnished by Personnel who have been appropriately trained and are qualified to furnish such services. Documentation of such qualifications (e.g., certificate of completion from a State Department of Health approved training program) will be maintained. The Agency will take steps on a regular basis to monitor and ensure such compliance.

- The Agency also appropriately accesses the Home Care Worker's Registry information prior to the worker beginning to provide home care services on the Agency's behalf. The Agency also conducts criminal history record checks pursuant to federal and state law on Personnel involved in providing care.

- In addition to the general credentialing process, the Agency will confirm the identity and determine the exclusion status of all Affected Individuals. In doing so, we will review the following State and Federal databases at least every thirty (30) days: (a) the OMIG Exclusion List; (b) the U.S Department of Health and Human Services Office of Inspector General's (the "OIG") List of Excluded Individuals and Entities (c) the General Services Administration's System for Award Management. Our Contractors are also required to comply with these requirements. The results of such checks will be promptly shared with the Compliance Officer and other appropriate compliance personnel. For more information, see our Compliance Reviews for Excluded or Ineligible Individuals/Entities Policy.

- If you have been found to have violated the law or receive notification of exclusion from Medicare, Medicaid or any Federal health care program, you must report such information, in writing, to the Compliance Officer within two (2) business days. Upon receipt of any conviction or exclusion report, Compliance Counsel, the Compliance Officer, and the Director of Human Resources will assess whether your conviction or exclusion violates the Compliance Program.

- The Agency has strict standards in place regarding quality of care. The Quality Assurance Director will be responsible for overseeing quality of care issues. The Agency has established processes by which quality assurance reviews are conducted, issues are addressed, and corrective actions are implemented. In addition, the Agency has established protocols for reviewing complaints from patients and third parties and addressing issues which may arise.

- The Agency is committed to protecting and promoting the rights of all patients, including, but not limited to, patients' rights to respect, privacy, to participate in the planning of their own care and to submit complaints about care and services. The Agency will provide all patients with written notice of their rights prior to the initiation of care.

- Health care services will only be provided after a determination has been made by a registered nurse (or by an individual directly supervised by a registered nurse) indicating that the patient's health and safety needs can be met safely and adequately at home by the Agency.

- Home Care services will be provided consistent with the services ordered by a physician and authorized by the Managed Long Term Care ("MLTC") Plan (as applicable) for the patient.

- Personal care and home health aide services will be furnished under the appropriate supervision of a registered nurse, licensed practical nurse or professional therapist (if the aide carries out simple procedures as an extension of physical therapy, occupational therapy or speech language pathology) and documentation evidencing such supervision will be maintained. The required frequency of nursing supervision visits should be stated in the Plan of Care. The individual responsible for supervising the aide is required to prepare patient-specific written instructions for the aide based on the patient's assessed individualized needs.

- The Agency will only provide rehabilitative services, such as physical therapy, occupational therapy, and speech language pathology, pursuant to a written care plan and a physician order. Orders must include the specific procedures and modalities to be used and the amount, frequency and duration of such services. Services must be reasonable and necessary for treatment of the patient, based on the patient's actual clinical condition. The provision of these services, including session length, will be accurately documented.

- The Agency will only submit claims for payment to payers for services that are medically necessary or that otherwise constitute a covered service and are consistent with the payer's applicable policies and requirements.

☐ **Standards Related to Coding, Billing and Documenting Services**

- The Agency will comply with the coding, billing, documentation and submission rules and requirements of all of its payers, including government payers such as Medicare and Medicaid, and commercial payers, as well as all applicable Federal and State laws, rules and regulations governing the coding, billing, documentation and submission of claims. ***For more information,*** see our Billing, Coding and Documentation Policy.

- The Agency is committed to preparing accurate claims, consistent with such requirements. All coding, billing and documentation of services must be accurate and truthful.

- Specifically, among other rules, we follow 18 NYCRR § 521-1.3(d):

- **Risk areas.** The compliance program shall apply to the required provider's risk areas, which are those areas of operation affected by the compliance program and shall apply to: (1) billings; (2) payments; (3) ordered services; (4) medical necessity; (5) quality of care; (6) governance; (7) mandatory reporting; (8) credentialing; (9) contractor, subcontractor, agent or independent contract oversight; (10) other risk areas that are or should reasonably be identified by the provider through its organizational experience.

- You may never misrepresent charges or services to or on behalf of the government, a patient or a payer. False statements, intentional omissions or deliberate and reckless misstatements to government agencies, payers or others will expose those involved to disciplinary action. As but one example, no Affected Individual will knowingly engage in any form of upcoding of any service in violation of any law, rule, regulation or requirement. Among other things, any Affected Individual involved in such activities is subject to potential termination of employment or contract, and potential criminal and civil liability.

- Billing codes - including CPT, HCPCS and ICD diagnostic codes - should never be selected on the basis of whether the given code guarantees or enhances payment. Rather, only those codes that correspond to the actual service rendered and documented should be selected.

- Only those services that are consistent with accepted standards of care may be billed. In this regard, billing and coding must always be based on adequate documentation of the justification for the service provided and for the bill submitted, and this documentation must comply with all applicable requirements.

- We also comply with all associated and applicable Federal and State laws, rules and regulations that relate to the coding, billing and documentation of services including, but not limited to those concerning: the ordering of services; waiving coinsurance or other patient financial responsibility amounts; providing professional courtesy to physicians or their families; obtaining Advance Beneficiary Notices from Medicare patients for non-covered services; and gathering insurance information from patients.

- In accordance with **Federal and New York State law**,[1] the Agency provides to all Affected Individuals a detailed description of: (i) the Federal False Claims Act; (ii) the Federal Program Fraud Civil Remedies Act; (iii) State civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws. The Agency also provides Affected Individuals with detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste, and abuse. The employee handbook also includes specific discussion of the laws described above, the rights of employees to be protected as whistleblowers, and the Agency's policies and procedures for detecting and preventing fraud, waste and abuse.

[1] See 42 USC § 1396a(a)(68); 18 NYCRR § 521-1.4(2)(ix).

- The Agency does not retain any payments to which it is not entitled. The Agency will timely report, return and explain any identified overpayments in accordance with applicable law, rules, regulations and requirements. ***For more information,*** see "Mandatory and Other Reporting" below; and

  ***For more information,*** see the Billing, Coding and Documentation Policy; the Waiving/Reducing Coinsurance, Copayment and Deductible Amounts Policy; the Compliance with Anti-Referral Laws Policy; and the Compliance with Federal and State False Claims Laws (Overview of the Laws Regarding False Claims and Whistleblower Protections/Policy.

- Although the Agency does not directly submit claims to Federal health care programs, the services we provide pursuant to contracts with certified home health agencies are submitted for such payment. Those claims are based on our documentation of services and our compliance with applicable law and regulations. All Personnel providing services through the Agency must do so in accordance with regulatory standards as to quality of care, frequency of care and level of care. Additionally, such Personnel must be qualified to provide the service and receive adequate supervision.

- Although the Agency's documentation of service may be submitted to an outside company to perform the billing function, the Agency remains responsible for the accuracy of all claims submitted to private and government payers. The Agency will ensure that the billing company has implemented its own Compliance Program and, among other things, performs regular audits of claims submitted on the Agency's behalf. If any claims submitted are found to have been improper, the Agency will work with the billing company to resolve the issue(s) and refund any overpayments received or take other corrective action, as necessary and appropriate.

- Documentation of patient care must be accurate and truthful, with no misrepresentations regarding services provided. If the entity responsible for submitting claims has any question as to the accuracy of the documentation of services provided or if the medical record is unclear, the Agency Personnel must cooperate with any request for clarification or additional information.

- Personnel must take the necessary steps to prevent the submission of claims for payment and reimbursement that are fraudulent, abusive, and inaccurate or for medically unnecessary services. The following practices are prohibited:

  1. Falsifying the amount of time spent providing care to a patient;
  2. Failing to provide services as required by the plan of care/medical orders;
  3. Falsely or inaccurately documenting services in the progress notes or plan of care;
  4. Providing misleading information about a patient's medical condition;
  5. Failing to meet the standard of supervision required;

6. Forging a health care professional's or patient's signature on documents.

   Personnel involved in such activities are subject to termination of employment or contract, and potential criminal and civil liability.

- The Agency will comply with all Federal and State laws relating to matters including, but not limited to: obtaining Advance Beneficiary Notices from Medicare patients for non-covered services; gathering insurance information from patients; and the retention of billing and medical records.

☐ **Standards Relating to Business Practices**

- All business records must be accurate, truthful and complete, with no material omissions.

- The Agency will forego any business transaction or opportunity that can only be obtained by improper or illegal means and will not make any unethical or illegal payments to induce or reward the use of our services.

- No Affected Individuals will engage, either directly or indirectly, in any corrupt business practices intended to influence the manner in which the Agency performs services, or otherwise engages in business practices.

- Financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Sufficient and competent evidential matter or documentation shall support all cost reports.

- The Agency will not engage in anti-competitive conduct that could produce an unreasonable restraint of trade of a substantial lessening of competition. Communication by employees with competitors about matters that could be perceived to have the effect of lessening competition or could be considered as collusion or an attempt to fix prices should take place only after consultation with legal counsel.

  ***For more information,*** see the Billing, Coding and Documentation Policy; the Compliance with Anti-Referral Laws Policy; the Compliance with Federal and State False Claims Laws (Overview of the Laws Regarding False Claims and Whistleblower Protections/Policy; the Gifts and Benefits Policy; and the Conflict of Interest Policy.

☐ **Standards Relating to Record Retention and Access to Records**

- The Agency will comply with all applicable laws, rules, regulations and requirements relating to the retention of billing and medical records.

- The Agency will make available to the New York State Department of Health ("DOH"), the OMIG and the MFCU, upon request, all records demonstrating that we have adopted, implemented and operate an effective compliance program and have satisfied the requirements of 18 NYCRR Subpart 521. Such records will be retained by the Agency

for a period not less than six (6) years from the date the program was implemented, or any amendments thereto were made, in accordance with 18 NYCRR § 521-1.3(b), or for such longer period of time as may be required by applicable laws, rules, regulations or contractual requirement.

- In order to help ensure the effectiveness of the Compliance Program, the Compliance Officer and appropriate compliance personnel will have access to all records, documents, information, facilities and Affected Individuals that are relevant to carrying out their Compliance Program responsibilities.

☐ **Standards Relating to Conflicts of Interest**

- All members of the Covered Group must avoid any and all activities that conflict with their responsibilities and obligations to the Agency and its Patients.

  i. Members of the Covered Group must not have an interest in or serve as director, officer, manager, or member of an entity in competition with the Agency, without permission.

  ii. Any members of the Covered Group who performs work or renders service for any competitor of the Agency or for any organization which does business with or seeks to do business with the Agency outside the normal course of his or her employment or other engagement with the Agency must notify the Compliance Officer or the Administrator.

  iii. Engaging in business with any Agency vendor, supplier, contractor, or agency of any of their officers or employees that is not conducted on behalf of the Agency is prohibited, unless previously authorized by the Compliance Officer or the Administrator.

  iv. Staff members may not permit their names to be used in any fashion that would tend to indicate a business connection with any organization which does business with or seeks to do business with the Agency without the prior approval of the Compliance Officer or the Administrator.

  v. The Agency may not be represented by a member, manager, officer, director, or employee, contractor or agent in any transaction in which he or a relative has a personal or financial interest.

- In accordance with the Agency's Conflict of Interest and Related Party Transactions Policy, members of the Covered Group are required to disclose actual and potential conflicts of interest involving themselves or their relatives to the Compliance Officer using the Agency's "Conflict of Interest Disclosure Statement."

☐ **Patient Referrals/Marketing Activities**

- In general, Federal and State anti-kickback laws prohibit offering, paying, soliciting or receiving any remuneration to induce or reward referrals of items or services that are reimbursed by a Federal health care program (including, but not limited to, Medicare and Medicaid). This includes the giving of any form of remuneration, including virtually anything of value, in return for a referral. The decision to refer patients is a separate and independent clinical decision made by physicians or other appropriate licensed practitioners. In certain situations, there may be exceptions and/or "safe harbors" to the anti-kickback laws. The Agency does not offer, pay, solicit or receive remuneration to or from physicians, or anyone else, either directly or indirectly, for patient referrals, in violation of applicable laws, rules and/or regulations. ***For more information,*** see our Compliance with Anti-Referral Laws Policy; and our Compliance with Federal and State False Claims Laws (Overview of the Laws Regarding False Claims and Whistleblower Protections) Policy.

- All marketing activities and advertising by Affected Individuals must be truthful and not misleading, must be supported by evidence to substantiate any claims made and must otherwise be in accordance with applicable laws, rules and regulations. In this regard, our best "advertisement" is the quality of the services we provide. You should never disparage the service or business of a competitor through the use of false or misleading representations.

- You may not offer, pay, solicit or receive any gifts or benefits to or from any person or entity that would compromise the Agency's integrity (or even create an appearance that the Agency's integrity is compromised), or under circumstances where the gift or benefit is offered, paid, solicited or received with a purpose of inducing or rewarding referrals or other business between the parties, in violation of applicable laws, rules, regulations or requirements. The guiding principle is simple: Affected Individuals may not be involved with gifts or benefits that are undertaken to influence any business decision in a manner that violates the law. Cash or cash equivalents may not be given or accepted under any circumstances. ***For more information,*** see our Gifts and Benefits Policy; and our Compliance with Anti-Referral Laws Policy.

☐ **Mandatory and Other Reporting**

- As part of its commitment to providing high quality care and services, the Agency complies with all applicable Federal and State mandatory reporting laws, rules and regulations. To this end, the Agency will ensure that all incidents and events that are required to be reported are reported in a timely manner and will monitor compliance with such requirements. This includes required reporting to appropriate government agencies or parties.

- The Agency will also ensure its compliance with the requirement that, upon enrollment and annually thereafter, it certifies that it has met the requirements of New York Social Services Law (*i.e.*, N.Y. Social Services Law § 363-d and 18 NYCRR Subpart 521-1).

Further, the Agency will provide a copy of the certification required by 18 NYCRR § 521-1.3 to each Medicaid Managed Care Organization (including managed care providers and managed long term care plans) (collectively, "MMCO") for which it is a participating provider upon signing the participating provider agreement with the MMCO, and annually thereafter. As applicable, the Agency will also comply with other State and Federal certification requirements that are or may become applicable to it.

- The Agency will ensure that all identified overpayments are timely reported, returned and explained in accordance with applicable laws, rules, regulations and requirements. For example, it is our policy to exercise reasonable diligence in identifying overpayments, not to knowingly retain any funds which are received as a result of overpayments and to report, return and explain any overpayments received from Federal health care programs (including, for example, but not limited to, Medicare and Medicaid) within 60 days from the date the overpayment is identified (or within such time as is otherwise required by law or contract). Any such monies that are improperly collected will be refunded, in accordance with applicable laws, rules, regulations and requirements, to the appropriate party at the correct address. ***For more information,*** see our Protocols for Investigation and Implementing Corrective Action, Including Discipline Policy.

- Moreover, in appropriate circumstances (e.g., after an internal investigation confirms possible fraud, waste, abuse or inappropriate claims), the Agency will utilize the appropriate self-disclosure process and report, as necessary and appropriate, to the OMIG, OIG, the Centers for Medicare and Medicaid Services, or other appropriate payer/agency. In such circumstances, the Agency may consult with legal counsel or other experts, as needed. **For more information,** see our Protocols for Investigation and Implementing Corrective Action, Including Discipline Policy.

☐ **Standards Relating to Confidentiality and Security**

- In compliance with Federal and State privacy laws, all Affected Individuals will keep patient information confidential and secure.

- The posting of any Agency patient's information or picture to social media is strictly prohibited.

- The Agency has also implemented and maintains a HIPAA Compliance Program that addresses privacy and security. All Affected Individuals must adhere to the standards of the HIPAA Compliance Program.

- Confidential information acquired by Affected Individuals about the business of the Agency must also be held in confidence and not used for personal gain, either directly or indirectly, or in any manner that violates applicable laws, rules, regulations or requirements.

☐ **Government Inquiries**

- It is the Agency's policy to comply with applicable laws, rules, regulations and requirements, and to cooperate with legitimate government investigations or inquiries. All responses to requests for information must be accurate and complete and must not omit any material information. Any action by Affected Individuals to destroy, alter, or change any of the Agency's records in response to a request for such records is strictly prohibited and will subject them to immediate termination of employment or contract and possible criminal prosecution, among other things.

- You may speak voluntarily with government agents, and the Agency will not attempt to obstruct such communication. It is recommended, however, that you contact the Compliance Officer before speaking with any government agents.

- You must receive authorization from the Compliance Officer before responding to any request to disclose the Agency's documents to any outside party.

- It is the Agency's policy to comply with applicable laws, rules, regulations and requirements, and to cooperate with legitimate government investigations or inquiries. All responses to requests for information must be accurate and complete and must not omit any material information. Any action by Affected Individuals to destroy, alter, or change any of the Agency's records in response to a request for such records is strictly prohibited and will subject them to immediate termination of employment or contract and possible criminal prosecution, among other things.

- It also is our policy to comply with all lawful directives of the DOH, OMIG or other appropriate government agencies with respect to the adoption, implementation, and maintenance of our Compliance Programs pursuant to applicable laws, rules and regulations, including, but not necessarily limited to, 18 NYCRR Subpart 521-1.

  ***For more information,*** see our Responding to Government Inquires Policy.

☐ **Specific Compliance Provisions for Agreements with Contractors**

- It is the policy of the Agency to ensure that all contracts with our Contractors specify that the Contractor is subject to our Compliance Program, to the extent that the Contractor is affected by our risk areas (within the scope of the contracted authority and affected risk areas). We will follow OMIG's guidance regarding agreements in place prior to the effective date of OMIG's updated compliance regulations. ***For more information,*** see our Contractor Requirements Policy.

- In addition, such contracts will also include termination provisions for the failure to adhere to our Compliance Program requirements.

# Compliance Program Structure and Guidelines

The following elements comprise the Compliance Program's Structure and Guidelines. Each element governs a different and important aspect of the Compliance Program. The Structure and Guidelines are intended to provide you with an overview of the Compliance Program's framework that supports its day-to-day operations. The framework is designed to allow room for continuous improvement in, and evolution of, the Compliance Program so as to ensure that we continue to conduct business in a manner that supports integrity and ethics in our operations and compliance with the laws, rules, regulations and requirements to which we are subject.

**ELEMENT 1: Written Policies and Procedures**

- **Formal Policies.** The Code of Conduct, the Compliance Program Structure and Guidelines, and our specific Compliance Policies and Procedures (*i.e.*, our Compliance Manual) have all been formalized in writing and adopted by the Agency. These documents demonstrate our commitment to complying with applicable legal, regulatory and other requirements, appropriate guidance, and our contractual commitments.
- Specifically, the Agency's written Compliance Policies and Procedures and the Code of Conduct are designed to:

  i. Articulate our commitment and obligation to comply with all applicable Federal and State standards. In so doing, we have identified governing laws and regulations that are applicable to our risk areas, including, but not limited to, applicable Federal health care programs (*i.e.*, Medicare and Medicaid) policies and procedures;

  ii. Describe compliance expectations as embodied in standards of conduct (*i.e.*, our Code of Conduct). These standards of conduct serve as a foundational document which describe our fundamental principles and values, and our commitment to conduct our business in an ethical manner;

  iii. Document the implementation of our Compliance Program and its requirements, and outline its ongoing operation. Among other things, our Compliance Policies and Procedures are designed to describe, at a minimum, the structure of our Compliance Program, including the responsibilities of all Affected Individuals in carrying out the functions of the Compliance Program;

  iv. Provide guidance to Affected Individuals on dealing with potential compliance issues. Specifically, our guidance is designed to, at a minimum: (a) assist Affected Individuals in identifying potential compliance issues, questions and concerns, set forth expectations for reporting compliance issues, and explain how to report such issues, questions, and concerns to the Compliance Officer; and (b) establish the expectation that all Affected Individuals will act in accordance with the standards of conduct, that they must refuse to participate in unethical or illegal conduct, and that they must report any unethical or illegal conduct to the Compliance Officer;

  v. Identify the methods and procedures for communicating compliance issues to the appropriate compliance personnel;

vi. Describe how we investigate and resolve potential compliance issues and the procedures for documenting the investigation, and the resolution or outcome (***for more information,*** see our Protocols for Investigation and Implementing Corrective Action, Including Discipline Policy);

vii. Include a policy of non-intimidation and non-retaliation for good faith participation in the Compliance Program, including, but not limited to: (a) reporting potential compliance issues to appropriate personnel; (b) participating in investigation of potential compliance issues; (c) self-evaluations; (d) audits; (e) remedial actions; (f) reporting instances of intimidation or retaliation; and (g) reporting potential fraud, waste or abuse to the appropriate State or Federal entities (***for more information***, see the Non-Retaliation, Non-Intimidation for Participation in the Compliance Program Policy; and the Protocols for Investigations and Implementing Corrective Action, Including Discipline Policy);

viii. Include a written statement setting forth our policy regarding Affected Individuals who fail to comply with the written policies and procedures, standards of conduct, or State and Federal laws, rules and regulations. That policy, which may be found in our Protocols for Investigation and Implementing Corrective Action, Including Discipline Policy, also establishes our standards for taking and escalating disciplinary actions that must be taken in response to non-compliance. Generally speaking, intentional or reckless behavior is subject to more significant sanctions. Sanctions may include oral or written warnings, suspension, and/or termination;

ix. Additionally, we also comply with the requirements of the Federal Deficit Reduction Act (42 USC § 1396a(a)(68)) as to maintaining and disseminating policies regarding false claims law and whistleblower protections (***for more information,*** see our Compliance with Federal and State False Claims Laws (Overview of the Laws Regarding False Claims and Whistleblower Protections) Policy);

and

x. We will meet at least annually to review all Compliance Program Policies and Procedures and standards of conduct in order to determine: (i) if such written policies, procedures, and standards of conduct have been implemented; (ii) whether Affected Individuals are following the policies, procedures, and standards of conduct; (iii) whether such policies, procedures, and standards of conduct are effective; and (iv) whether any updates are required. Policies will be reviewed and approved by the Compliance Committee, Compliance Officer, and CEO on an annual basis.

**ELEMENT 2: Designation of Compliance Officer and the Compliance Committee**

- **Duties of the Compliance Officer.** The Compliance Officer is the focal point of our Compliance Program and is responsible for the Program's day-to-day operations.

  The Compliance Officer's primary responsibilities include:

  i. Overseeing and monitoring the adoption, implementation and maintenance of the Compliance Program and evaluating its effectiveness;

  ii. Drafting, implementing, updating and coordinating a compliance work plan no less frequently than annually or, as otherwise necessary, to conform to changes to Federal and State laws, rules, regulations, policies and standards. The work plan will outline our proposed strategy for meeting the requirements of an effective compliance program for the coming year, with a specific emphasis on applicable requirements relating to our written Compliance Policies and Procedures, training and education, auditing and monitoring, and responding to compliance issues;

  iii. Reviewing and revising the Compliance Program, and, at least annually, the written Compliance Policies and Procedures and standards of conduct, to incorporate changes based on our organizational experience and promptly incorporate changes to Federal and State laws, rules, regulations, policies and standards. We will also conduct a review, at least annually, to determine whether such Policies and Procedures and standards of conduct have been implemented, are being followed by Affected Individuals, and whether they are effective and/or any updates are required;

  iv. Reporting directly, on a regular basis, but no less frequently than quarterly, to the Agency's governing body, chief executive, and Compliance Committee on the progress of adopting, implementing, and maintaining the Compliance Program;

  v. Assisting in establishing methods to improve our efficiency, quality of services, and reducing our vulnerability to fraud, waste and abuse; and

  vi. Investigating and independently acting on matters related to the Compliance Program, including designing and coordinating internal investigations and documenting, reporting, coordinating, and pursuing any resulting corrective action with all internal departments, contractors and the State.

  The Agency is committed to ensuring that the Compliance Officer is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the Compliance Program, based on our risk areas and organizational experience. We will assess our allocation of staff and resources as part of our annual review of our Compliance Program's effectiveness (see, "Annual Compliance Program Review" in Element 6, below).

- **Duties of the Compliance Committee.** A Compliance Committee has been formed to coordinate with the Compliance Officer in order to ensure that we are conducting our business in an ethical and responsible manner, consistent with the Agency's Compliance Program. The Compliance Committee operates pursuant to a written charter. Among other things, the charter outlines the duties, responsibilities and membership of the Committee, designates a Chair and

outlines the frequency of the Committee's meetings. We review the charter no less frequently than annually.

The Compliance Committee meets no less frequently than quarterly, and reports directly to, and is accountable to, the chief executive officer and our governing body. The Committee's membership consists, at a minimum, of senior managers.

The Compliance Committee's responsibilities include:

i. Coordinating with the Compliance Officer to ensure that our written Compliance Policies and Procedures, and standards of conduct, are current, accurate and complete, and that the training topics that are part of our Compliance Program are timely completed;

ii. Coordinating with the Compliance Officer to ensure communication and cooperation by Affected Individuals on compliance-related issues, internal or external audits, or any other function or activity required by applicable law, regulation or requirement;

iii. Advocating for the allocation of sufficient funding, resources and staff for the Compliance Officer to fully perform their responsibilities;

iv. Ensuring that we have effective systems and processes in place to identify Compliance Program risks, overpayments and other issues, and effective Compliance Policies and Procedures for correcting and reporting such issues; and

v. Advocating for adoption and implementation of required modifications to the Compliance Program.

***For more information,*** see the Compliance Monitoring, Risk Assessment and Training Policy.

**ELEMENT 3: Training and Education**

- As an integral part of the Compliance Program, we have established and implemented an effective compliance training and education program. This program applies to all Affected Individuals and to our Compliance Officer.
- Affected Individuals and the Compliance Officer will complete the training program no less frequently than annually. Our training and education program is a part of the orientation of new Compliance Officers and Affected Individuals and occurs promptly upon hiring (*i.e.*, within 30 days of their start date).
- Training is provided in a form and format that is accessible and understandable to all Affected Individuals, consistent with applicable language and other access laws, rules or policies.
- The Compliance Program also has a training plan. At a minimum, our training plan outlines the subjects or topics for training and education, the timing and frequency of the training, which Affected Individuals are required to attend, how attendance will be tracked, and how the effectiveness of the training will be periodically evaluated.
- The Agency's training and education includes, at a minimum, the following topics:
    i. Our risk areas and organizational experience;
    ii. Our written Compliance Policies and Procedures as identified above in Element 1, "Written Policies and Procedures";
    iii. The role of the Compliance Officer and the Compliance Committee;
    iv. How Affected Individuals can ask questions and report potential compliance-related issues to the Compliance Officer and senior management, including the obligation of Affected Individuals to report suspected illegal or improper conduct and the procedures for submitting such reports, and the protection from intimidation and retaliation for good faith participation in the Compliance Program;
    v. Disciplinary standards, with an emphasis on those standards related to our Compliance Program and the prevention of fraud, waste and abuse;
    vi. How we respond to compliance issues and implement corrective action plans;
    vii. Requirements specific to payors for the categories of service we provide (e.g., Medicare and Medicaid requirements);
    viii. Coding and billing requirements and best practices; and
    ix. Claim development and the submission process.

***For more information,*** see the Compliance Monitoring, Risk Assessment and Training Policy.

**ELEMENT 4: Effective Lines of Communication**

- **Communication System.** The Agency has established and implemented effective lines of communication, ensuring confidentiality for Affected Individuals. The lines of communication are accessible, allow compliance issues to be reported as they are identified and include methods for anonymous and confidential good faith reporting of potential compliance issues.

  Specifically:

  i. Our lines of communication are accessible to all Affected Individuals and allow for questions regarding compliance issues to be asked and for compliance issues to be reported;

  ii. We publicize the lines of communication to the Compliance Officer and they are made available to all Affected Individuals, as well as to all Medicaid recipients of service;

  iii. We have a method for anonymous reporting of potential fraud, waste and abuse, and compliance issues directly to the Compliance Officer;

  iv. We ensure that the confidentiality of persons reporting compliance issues is maintained unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding, and that such persons are protected under our policy for non-intimidation and non-retaliation (***for more information, see*** the Non-Retaliation, Non-Intimidation for Good Faith Participation in the Compliance Program Policy;) and

  v. We make available on our website, information concerning our Compliance Program, including our standards of conduct.

- "**Open Door Policy.**" The Agency has an "open door" policy for receiving reports and for answering questions concerning adherence to the law and the Compliance Program.

- **Reporting Issues.** All Affected Individuals must abide by the Compliance Program and are required to report suspected illegal or improper conduct, possible violations of the Compliance Program and other compliance-related concerns. Affected Individuals may report issues to the Compliance Officer**,** to the Compliance Hotline, or to their supervisor or to management.

- **Reporting to the Compliance Officer.** If a report is made to a supervisor or management or anyone other than the Compliance Officer, that person must in turn immediately inform the Compliance Officer so that the issues may be addressed.

- **Anonymous and Confidential Reporting Methods.** Personnel may report issues or concerns anonymously if they so choose. Personnel may report anonymously by calling the Compliance Hotline. Personnel may also choose to identify themselves. In such case, the reporting person's identity will be kept confidential, whether requested or not, unless the matter is subject to a disciplinary proceeding, is referred to, or is under investigation by, the MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding.

- **Retaliation or Intimidation is Prohibited.** Retaliation or intimidation in any form against an individual who reports possible misconduct or illegal conduct, or otherwise participates in good

faith in the Compliance Program, is strictly prohibited. Acts of retaliation or intimidation should be immediately reported to the Compliance Officer, or to the Hotline and, if substantiated, the individuals responsible will be appropriately disciplined (***for more information, see*** the Non-Retaliation, Non-Intimidation for Good Faith Participation in the Compliance Program Policy).

**ELEMENT 5: Disciplinary Standards to Encourage Good Faith Participation in the Compliance Program**

- The Agency has established well-publicized disciplinary standards, and has implemented enforcement procedures for those standards, in order to address potential violations and to encourage good faith participation in the Compliance Program by all Affected Individuals.
- Specifically, our written Compliance Policies and Procedures establishing our disciplinary standards and the procedures for taking such actions are published and disseminated to all Affected Individuals and are incorporated into our training plan. Moreover, we enforce our disciplinary standards fairly and consistently, and the same disciplinary action applies to all levels of personnel.
- The types of discipline imposed will be commensurate with the severity of the violation, and may include one or more of the following: training, re-training, verbal warnings, written warnings, suspension and/or termination of employment or contract, as appropriate, under the circumstances.

  ***For more information,*** see the Protocols for Investigations and Implementing Corrective Action, Including Discipline.

**ELEMENT 6: The System for Routine Monitoring and Identification of Compliance Risk Areas; Annual Compliance Program Reviews; Excluded Provider Checks**

- The Agency has established an effective system for the routine monitoring, identification and assessment of compliance risks. This system includes, but is not limited to, internal monitoring and audits, and, as appropriate, external audits, to evaluate the Agency's compliance with Federal health care program (*e.g.,* Medicare and Medicaid) requirements and the overall effectiveness of the Compliance Program.
- **Routine Monitoring and Auditing.** Routine audits will be performed by internal or external auditors who have expertise in applicable State and Federal requirements (*e.g.*, the Medicare and Medicaid Programs) and other applicable laws, rules, regulations and requirements, or have expertise in the subject area of the audit.
- **Specific Risk Areas, Documentation and Reporting.** Our audits and monitoring will meet the following requirements, at a minimum: (i) internal and external compliance audits will focus on our risk areas; (ii) the results of all internal or external audits, or audits conducted by the State or Federal government will be reviewed for risk areas that can be included in updates to our Compliance Program and compliance work plan; and (iii) the design, implementation, and results of any internal or external audits will be documented, and the results shared with the Compliance Committee and our governing body.
- **Overpayments and Corrective Actions.** Any identified overpayments, including, but not limited to Medicaid or Medicare identified overpayments, will be reported, returned and explained in accordance with applicable laws, rules, regulations and requirements, including for instance, NY Social Services Law § 363-d, 18 NYCRR Subpart 521-3 and 42 USC § 1320a-7k(d), and the Agency will promptly take corrective action to prevent recurrence of the issues that caused the overpayment.
- **Annual Compliance Program Review.** The Agency also has a process to review, at least annually, whether our Compliance Program is effective, whether any revision or corrective action is required, or whether there should be any other changes or modifications to the Compliance Program.

  Specifically:

  i. This review may be carried out by the Compliance Officer, Compliance Committee, external auditors, or other staff we designate, provided that such other staff has the necessary knowledge and expertise to evaluate the effectiveness of the components of the Compliance Program they are reviewing and are independent from the functions being reviewed;

  ii. The review should include on-site visits, interviews with Affected Individuals, review of records, surveys, or any other comparable method that is appropriate, provided that it does not compromise the independence or integrity of the review;

  iii. We will document the design, implementation and results of our effectiveness review, and any corrective action implemented; and

iv. The results of our annual Compliance Program review will be shared with the chief executive, senior management, Compliance Committee and the governing body.

- **Excluded Provider Checks.** In accordance with the requirements of 18 NYCRR § 515.5 and 18 NYCRR § 521-1.4 (g)(3), we will confirm the identity, and determine the exclusion status, of Affected Individuals. Specifically, in determining the exclusion status of a person, we will review, at a minimum, the following databases at least every thirty (30) days: (a) the OMIG Exclusion List; (b) the OIG's List of Excluded Individuals and Entities; and (c) the General Services Administration's System for Awards Management. The results of these checks will be promptly shared with the Compliance Officer and appropriate compliance personnel. Further, we require our Contractors to perform these checks as well.

  ***For more information,*** see the Compliance Monitoring, Risk Assessment and Training Policy; the Protocols for Investigations and Implementing Corrective Action, Including Discipline; and our Compliance Reviews for Excluded or Ineligible Individuals/Entities Policy.

**ELEMENT 7: The System for Promptly Responding to Compliance Issues**

- The Agency has established and implemented procedures and systems for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of the internal auditing and monitoring, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with State and Federal laws, rules and regulations, and requirements, including those of the Medicare and Medicaid Programs. Our procedures and systems include the following:

  i. Upon the detection of potential compliance risks and compliance issues, whether through reports received, or as a result of auditing and monitoring, we will take prompt action to investigate the conduct in question and determine what, if any, corrective action is required, and likewise promptly implement such corrective action;

  ii. We will document the investigation of the compliance issue. Documentation will include any alleged violations, a description of the investigative process, copies of interview notes and other documents essential for demonstrating that a thorough investigation of the issue was completed. Where appropriate, we may retain outside experts, auditors, or counsel to assist with the investigation;

  iii. We will also document any disciplinary action taken and the corrective action implemented; and

  iv. If the Agency identifies credible evidence or credibly believes that a State or Federal law, rule or regulation has been violated, it will promptly report such violation to the appropriate governmental entity, where such reporting is otherwise required by law, rule or regulation. The Compliance Officer will receive copies of any reports submitted to governmental entities.

- **Investigations.** All compliance issues, however raised (*i.e.*, whether reported or discovered through audits/self-evaluations or other means), must be brought to the attention of the Compliance Officer.

- **Corrective Action and Responses to Suspected Violations.** When appropriate, corrective action plans will be created and tailored to the particular conduct and will provide a structure with time frames in order to attempt to ensure non-compliant activity does not recur. Corrective action will be implemented promptly and thoroughly and may include (but is not necessarily limited to): conducting training and education; revising or creating appropriate forms; modifying or creating new Compliance Policies and Procedures; conducting additional internal reviews, audits or follow-up audits; imposing discipline (up to and including termination of employment or contract), as appropriate and/or refunds to appropriate payers and/or self-disclosing to appropriate government agencies or payers. Corrective Action Plans and other corrective actions will continue to be monitored after they are implemented to ensure that they are effective.

  **For more information,** see the Compliance Monitoring, Risk Assessment and Training Policy; and the Protocols for Investigations and Implementing Corrective Action, Including Discipline.

# D1: Billing, Coding and Documentation

## POLICY

The Agency is dedicated to maintaining integrity in the billing, coding and documentation of the items and services it provides. In conformity with our basic mission and values, billing claims may only be submitted for actual services rendered and appropriately documented, and only when those items and services are provided in a manner that is consistent with accepted standards of medical care.

**1.** Accurate and Truthful Billing. All billing must be accurate and truthful. Affected Individuals may never misrepresent claims to, or on behalf of, a patient or third-party payer. Knowingly false statements or intentional omissions of material information by any personnel - whether to a government payer (such as Medicare or Medicaid), to a commercial payer or to a patient - will not be tolerated. Deliberate misstatements to any payers or patients will expose the personnel involved to disciplinary action, up to and including termination of employment or affiliation with the Agency. All disciplinary actions taken by the Agency will be in the Agency's sole discretion in accordance with, among other things, our Compliance Program policies and procedures. Affected Individuals who engage in fraudulent billing practices also risk exposure to criminal penalties.

Affected Individuals must avoid not only deliberate misstatements relating to claims the Agency submits, but reckless ones as well. Affected Individuals must also avoid submitting information relating to the Agency's claims with either a deliberate ignorance or a reckless disregard of its falsity or truth. Thus, if Affected Individuals have any question as to the truth or accuracy of any claims-related to documentation for billing purposes, or if there is material information that is missing, the claim for the services in question must be held until the uncertainties are resolved. Anything less is strictly prohibited.

**2.** Adequate Documentation. Billing must always be based on timely, accurate and complete documentation that demonstrates the medical necessity for the item or service provided and the appropriateness of the claim submitted. This medical documentation must comport with all applicable requirements. It is the responsibility of the medical professional to ensure that, prior to submitting charge documents for billing, the documentation for the item or service provided is clear and in conformity with such requirements. Each medical professional involved in the documentation process has an obligation to be aware of relevant Federal health care program requirements and to ensure that their documentation is accurate.

In order to ensure accurate medical record documentation, the Agency's medical professionals will compile medical records that, to the extent required:

**a.** Are clear and legible; and,

**b.** Include the reason for the encounter, any relevant history, physical examination findings, prior diagnostic test results, assessment, clinical impression/diagnosis, plan of care, date and identity and signature of the physician/practitioner; and

**c.** Clearly show the rationale for ordering diagnostic and other ancillary services (if any); and

**d.** Support the CPT, HCPCS and ICD-10 codes used for claims submission.

**3.** Correct Coding. All Federal and State regulations governing correct coding procedures will be followed. All relevant personnel will be trained in the appropriate rules governing billing and coding. Procedural or diagnostic codes (i.e., CPT/HCPCS/ICD-10 codes) may never be selected simply on the basis of whether a given code guarantees or enhances payment. In addition, no defaults to a particular code may ever be used; rather, only those codes that appropriately correspond to the item or service actually rendered and documented in the medical record may be selected. The selected codes must be accurate and as specific as possible and must meet the payer's applicable coding requirements.

If billing personnel are uncertain for any reason as to what the proper code(s) should be, no claim will be processed until adequate information or clarification is received from the medical professional who provided the service. Affected Individuals may not select procedural or diagnosis codes based on their own interaction with a patient, from information provided during an earlier date of service, or based on what they might conclude is the probable or most likely procedure or diagnosis code.

If a claim is denied or if a payer requests additional information about a claim, any changes/corrections made to the codes that have been previously submitted must be supported by clear documentation in the medical record. It is prohibited for any of the Agency personnel to change a code simply in order to bypass a payer's edit, and to receive payment to which the Agency would otherwise not be entitled. The Agency does not provide financial incentives to physicians/[practitioners], employees, or others to code claims in a manner that would improperly enhance reimbursement.

**4.** Medical Necessity for Items and Services. The Agency will only submit claims to Medicare, Medicaid, any other Federal health care program and other third party payers for items and services that are medically necessary or that otherwise constitute a covered item or service. Medical necessity will be determined individually for each item or service provided or ordered by the responsible medical professional. [Medicare considers items and services to be reasonable and necessary if they are "for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.'' 42 U.S.C. 1395y(a)(1)(A). When the Agency provides services to a Medicare beneficiary, the Agency will only bill for those items and services that meet the Medicare standard of being reasonable and necessary for the diagnosis and treatment of a patient.]

**5.** Compliance with Federal and State Laws Regarding the Submission of Claims. Affected Individuals must comply with all applicable Federal and New York State laws and

regulations governing the submission of billing claims and related statements. A detailed description of (i) the Federal False Claims Act; (ii) the Federal Program Fraud Civil Remedies Act; (iii) New York State civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws is provided to all personnel, who will receive training on these laws as part of the Agency's Compliance Program. Affected Individuals should consult with the Compliance Officer (who may confer with the Agency's legal counsel, as necessary and appropriate) if they have questions about the application of these laws to their job.

**6.** Prompt Refunding of Overpayments. The Agency does not knowingly retain any payments that it is not entitled to keep and will promptly report, return and explain any overpayments identified in accordance with applicable law and contractual requirements. It is our policy to not retain any funds which are received as a result of an overpayment and to report, return and explain any overpayments within 60 days from the date the overpayment was identified. See Compliance Program Protocols for Investigations and Implementing Corrective Action, Including Discipline.

**7.** Waivers from Medicare Patients. If a physician/practitioner deems it clinically appropriate to provide an item or service that Medicare Part B may find to be medically unnecessary under its standards and thus not reimbursable, the ordering physician/practitioner needs to have the patient complete and sign a Medicare "Advance Beneficiary Notice of Non-coverage" ("ABN") prior to provision of the item or service. This notice informs the patient that the item or service may not be covered by Medicare and that he or she may be liable for paying for the service. In cases in which "medically unnecessary" services are performed for a Medicare patient, the patient generally may not be billed for the item or service without an ABN having been completed.

**8.** No Routine Waiver of Co-Payments, Co-Insurance and Deductible Amounts. The Agency does not routinely waive co-payments, co-insurance and deductible amounts. A waiver of such amounts may only be appropriate if the patient has a documented financial need and if it is in accordance with applicable legal and payer requirements. In general, the Agency will not waive any patient's co-payment, co-insurance or deductible unless the patient has an actual financial need and that need is documented and maintained in an appropriate record. Otherwise, all patients will be billed pursuant to normal procedures for collecting these amounts. Unpaid co-payments, co-insurance and deductible amounts will only be written off if normal, reasonable and good-faith collection efforts have failed and after appropriate consideration is given to the cost of further collection efforts.

**9.** Secondary Payer Rules. Affected Individuals responsible for billing must ensure that all secondary payer rules are followed so that incorrect billing and overpayments can be prevented. In particular, the Agency recognizes that Medicaid is the payer of last resort. In accordance with applicable Medicaid requirements, the Agency has instituted procedures reasonably designed to identify payers other than Medicaid and will make all reasonable and required efforts to identify other primary or secondary payers, or other responsible parties, and to bill accordingly.

**10.** Correct Use of Provider Identification Numbers. Every insurer to whom claims for payment are submitted, requires the use of identifying numbers on the claim form (e.g., National Provider Identification numbers, [tax identification numbers, group provider numbers]). Including the appropriate identifying numbers on claim submissions is essential to allow for timely processing of the claim. Moreover, the physician or provider who actually provided the service must be accurately and correctly reflected on the claim, consistent with payer requirements. The use of another's name or identification number, in lieu of the actual provider of service, may be considered fraud. If Affected Individuals have any questions regarding the correct use of identifying numbers in connection with claims for payment, they should contact the Compliance Officer.

**11.** Billing Software. The Agency will take all reasonable steps to ensure that its billing software reliably and accurately reflects up-to-date procedural, diagnosis and other codes, so that its claims for items and services may be submitted according to the most recent Federal, State and/or payer requirements and/or contractual requirements.

**12.** Retention of Records. All records that demonstrate the Agency's right to receive payment from payers, will be retained for a period of no less than ten (10) years from the date the items or services were provided or such time as required by law.

**13.** Compliance Reviews and Training. The Agency will conduct compliance assurance reviews on a regular basis, implement corrective action, as necessary and appropriate, and will educate and train Affected Individuals regarding applicable billing, coding and documentation requirements in accordance with the following policies:

- Compliance Monitoring, Risk Assessment and Training, and
- Protocols for Investigations and Implementing Corrective Action, Including Discipline.

# D2: Compliance Monitoring, Risk Assessment and Training

## POLICY

It is the policy of the Agency to conduct on-going risk assessments by having processes in place to continually monitor compliance with the Agency's Code of Conduct, its Compliance Program Policies and Procedures, and all applicable Federal and State laws, rules and regulations. To this end, the Agency has established and implemented an effective system for routine monitoring and identification of compliance risks. The Compliance Officer will ensure that specific compliance assurance reviews are conducted in accordance with the following procedures and protocols. The Compliance Officer will coordinate with his/her designees and the Compliance Committee to ensure that systems are in place for periodic compliance assurance reviews, tracking of new developments, and compliance training.

## PROCEDURE

### A. On-Going Risk Assessment

**1.** Compliance Assurance Reviews. On a periodic basis, the Compliance Officer, or his/her designee, will ensure that reviews are conducted to evaluate the Agency's compliance with federal health care program requirements *(e.g.,* the Medicare and Medicaid Programs) and the overall effectiveness of the compliance program. Internal, and as appropriate, external audits of the Agency's coding, billing and business practices will be conducted. Depending on the nature of the review or the results of a review, the Compliance Officer may work with legal counsel or outside consultants.

Such Compliance Assurance reviews may include, but are not limited to, the following:

**a.** Review of Billing Denials and Patient Complaints. Periodic reviews will be performed of denials from Medicare, Medicaid and other third-party payers in order to determine whether any patterns of improper billing exist that need correction. In addition, billing complaints from patients will also be tracked to determine whether such complaints reflect the existence of possible patterns of improper billing or other compliance issues. The findings from these reviews shall be communicated to the Compliance Officer, or his/her designee. Appropriate corrective action will be taken, as necessary.

**b.** Billing Reviews. Periodic reviews will be performed as to how services are ordered, performed and billed, utilizing external consultants and/or counsel, as necessary and appropriate. Such reviews will include the selection of a small sample of cases for review. If the review establishes a possible pattern of non-compliance, then appropriate corrective action, as outlined in the Compliance

Program policy entitled "Protocols for Investigations and Implementing Corrective Action," will be taken. Depending on the nature of the issue, the Compliance Officer may then contact legal counsel for further guidance and assistance.

**c.** Response to Third Party Audits. Following resolution of audits by third-party payers, the results of the audit will be reviewed by the Compliance Officer or his/her designee, to determine if those results reflect, among other things, any patterns, systemic deficiencies or problems with compliance with State or Federal rules, regulations or laws, contractual requirements and/or payer policies. If such a pattern, deficiency or problem is identified, appropriate corrective action will be taken, as necessary and appropriate.

**d.** Review of Compliance Issues. Periodically, the Compliance Officer will review reports received of suspected violations of the Code of Conduct and the Agency's Compliance Program Policies and Procedures to determine if there are any patterns of violations that might indicate broader compliance issues. Corrective action will be implemented as necessary and appropriate.

**e.** Business Reviews. Periodically, reviews will be conducted to spot check the Agency's business practices to ensure compliance with applicable laws, rules and regulations. Such checks might include, but are not limited to, a review of the Agency's marketing practices, the nature and scope of any free or discounted items or services being provided to patients, and, where applicable, reviews of relationships with physicians, providers and other relevant parties for compliance with Federal and State Anti-kickback and "Stark" laws and regulations. The findings from these reviews and other business practices that may implicate compliance issues, shall be communicated to the Compliance Officer. Corrective action will be implemented as necessary and appropriate.

**f.** Modification and Revision of Compliance Policies and Procedures. On at least an annual basis, the Compliance Officer will review and evaluate the effectiveness of the operation of the Compliance Program with the assistance of internal and external advisors, as necessary. Based on such reviews, the Compliance Officer will implement appropriate modifications of, or revisions to, compliance policies and procedures and/or other aspects of the Agency's Compliance Program.

**g.** Governance. The Compliance Officer will regularly report directly and be accountable to the Agency's Chief Executive Officer for reporting purposes regarding compliance issues that may arise.

**h.** Mandatory Reporting. The Compliance Officer will conduct reviews to ensure that all regulatory reporting obligations are met. Moreover, the Agency's Board

of Directors will ensure that annual New York and Federal compliance certifications (as applicable) are timely completed.

**i.** Credentialing. The Compliance Officer will ensure that all clinical personnel are appropriately credentialed (*i.e.*, properly licensed/certified and registered) and not listed on any federal or state exclusion list.

**j.** Annual Work Plan. The Compliance Officer will produce an annual work plan to the Board of Directors for its approval, that includes the specific compliance issues, audits and risk areas that will be addressed in the coming year. This may include, for instance, matters for which corrective action plans have been implemented that may require auditing or monitoring to confirm compliance. The Compliance Work Plan will address the following risk areas: billing and payments; medical necessity and quality of care issues; governance; mandatory reporting requirements as related to the Medicaid Program; credentialing and other risk areas identified by the Compliance Officer.

**k.** On-Going Report to the CEO/Governing Body. If any Compliance Assurance reviews detect compliance issues, the Compliance Officer shall report those issues to the Agency's Chief Executive Officer, and, as necessary, to the governing body. At the direction of the CEO and/or governing body, the Compliance Officer shall take all necessary and appropriate corrective action.

**l.** Recordkeeping. Documentation of the Agency's compliance assurance efforts will be maintained by the Compliance Officer or his/her designee. Such documentation will include, but not be limited to, copies of audit materials (including results), logs of calls to the Helpline or other compliance reports received by the Compliance Officer, and annual Compliance Work Plans and results of Work Plan activities.

**B. Tracking New Developments**

On a continuing basis, the Compliance Officer or his/her designee, will ensure that all new regulatory, legal and other requirements issued by Federal or State government agencies and commercial payers with which the Agency does business are reviewed by appropriate personnel. For example, such reviews may include, but are not limited to the following:

- Reviewing all new and revised rules and policies governing the coding and billing of physician services provided by the Agency;
- Receiving and reviewing relevant Medicare bulletins, Local and National Coverage Determinations, Medicaid updates, annual updates to the Current Procedural Terminology (CPT), or other relevant guidance and policy changes;

- Communicating with the appropriate professional society as to recent initiatives or developments that might affect the Agency, or new practices that might assist the Agency in complying with rules and regulations that specifically apply to it; and

- Reviewing (a) relevant Special Fraud Alerts and relevant Advisory Opinions or other guidance issued by the U.S. Department of Health and Human Services, Office of the Inspector General ("OIG"); (b) compliance alerts, and other guidance issued by the New York State Office of the Medicaid Inspector General ("OMIG"); and (c) guidance and policies issued by other payers with which the Agency does business.

- Reviewing all Work Plans issued by the OIG and OMIG.

Based on any relevant new developments, the Compliance Officer, or his/her designee, will review existing policies and procedures to ensure that the Agency is in compliance with the requirements of applicable Federal and State law and regulations as well as other contractual obligations. If necessary, appropriate corrective action will be taken.

**C. Compliance Training**

**1.** Policy Statement. It is the Agency's policy that the following Affected Individuals participate in compliance training and education activities annually: the Compliance Officer, employees, the Chief Executive, other senior administrators, managers, Board of Directors and any other Affected Individuals. Such training will occur no less frequently than annually and will include applicable laws, regulations and other requirements; how the Agency's Compliance Program operates (including, but not limited to: how and to whom to report issues, confidentiality, the investigation process, corrective actions, disciplinary policies, non-retaliation/non-intimidation policies, risk areas); and the Agency's expectations for Affected Individuals to abide by the Code of Conduct, report issues and assist in their resolution. The training and education will be made a part of the orientation of new compliance officers, employees and Affected Individuals and will occur promptly upon hiring.

**2.** Training Plan. The Agency will develop a training plan that includes, at a minimum an outline of the subjects or topics in the training and education, the timing and frequency of the training, who is required to attend, how attendance will be tracked, and how the effectiveness of training will be periodically evaluated. Training will also be provided upon new appointment of a Chief Executive, manager or Board of Directors.

This continuing education and training effort is of vital importance. Effective communication of applicable laws, regulations and policies will require development of, and participation in, training and educational programs, and may require dissemination of written materials, on a periodic basis. The Compliance Officer will be responsible for identifying and developing training regarding specific compliance risk areas. It is the

Agency's intention that, to the extent appropriate, training and educational programs be tailored to those individuals whose job requirements make the information relevant.

**3.** Code of Conduct/Policies & Procedures. The Compliance Officer is responsible for ensuring that information regarding the Compliance Program, including the Compliance Program Manual which contains the Reporting Requirements, Code of Conduct and the Compliance Program Structure and Guidelines, are distributed to all Affected Individuals and for maintaining a file containing each person's signed acknowledgment form. All newly hired persons must also receive a copy of the Compliance Manual during orientation and sign and return the acknowledgment form to the Compliance Officer. The Compliance Officer also must ensure that specific Compliance Program policies and procedures are distributed to appropriate Affected Individuals, as relevant to their job responsibilities at the Agency.

**4.** Billing Training. Billing personnel will be informed of all updates and modifications to the billing procedures and will be kept abreast of all bulletins and other relevant billing-related communications from State and Federal government agencies and commercial payers with which we contract. The Compliance Officer (or [his/her] designee) will ensure that internal billing guidelines and policies and procedures are revised or updated accordingly and distributed to all relevant personnel. Training sessions will also be conducted to improve billing accuracy and to ensure that all personnel understand any changes in procedure.

**5.** Mandatory Participation. Attendance and participation in training and educational programs are an important part of the Agency's business and professional environment. Thus, all Affected Individuals shall participate in appropriate education and training programs appropriate to their position and work at the Agency. These programs will reflect the Agency's commitment to compliance with applicable laws and regulations, and to appropriate ethical, professional and business standards. Adherence to the requirements of continuing education and training will be considered in the overall evaluation of the performance for each individual associated with the Agency. Failure to comply with education and training requirements may result in disciplinary action consistent with the gravity of such non-compliance, and is subject to legal and contractual rights, if any, applicable to such individual. The Compliance Officer will ensure that a process is in place to follow up with any Affected Individual that miss scheduled training sessions.

**6.** Recordkeeping. The Compliance Officer shall be responsible for maintaining records of the type of education and training program offered, the dates offered, and proof (e.g., a sign-in sheet) of those who attended the program. Educational and training files, including copies of all written materials, shall be retained for a period of no fewer than ten (10) years from the date the materials were last used.

**7.** Evaluation of Effectiveness. The Compliance Officer shall periodically (no less than annually) monitor, evaluate and annually assess the effectiveness of the Agency's education and training programs and shall revise such programs as necessary.

# D3: Compliance Reviews for Excluded or Ineligible Individuals/Entities

## POLICY

The Agency is committed to using good faith, reasonable efforts to not knowingly employ, contract with, or otherwise do business with, individuals or entities that are excluded, debarred or suspended from, or otherwise ineligible to participate in, Federal Health Care Programs or in Federal procurement or non-procurement programs.

This Policy and Procedure applies to our relationships and prospective relationships with:

1. All professional and non-professional members, and candidates to become members, of the Agency's staff, whether employed by, contracted with, or volunteers to, the Agency (collectively referred to as "Staff");
2. All physicians, practitioners and other providers who refer patients to, or order, prescribe or medically direct the provision of, items or services from, the Agency (collectively referred to as "Referring Providers"); and
3. All vendors and contractors who do business with, or seek to do business with, the Agency (collectively referred to as "Vendors").

## DEFINITIONS

The following definitions apply for purposes of this Policy and Procedure:

### A. Federal Health Care Program

A "Federal Health Care Program" is defined as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), or any State health care program. For example, some of the better known Federal Health Care Programs include, but are not limited to, Medicare, Medicaid, TRICARE and veterans' programs.

### B. Ineligible Person

An "Ineligible Person" means an individual or entity who/which has been excluded, debarred, suspended, terminated from, or is otherwise ineligible to participate in, any Federal Health Care Program or any Federal procurement or non-procurement program, and has not been reinstated after the period of exclusion, debarment, suspension, termination or ineligibility.

### C. Exclusion Lists

The "Exclusion Lists" include the following three internet sources that must be checked in accordance with the requirements of this Policy and Procedure:

- https://exclusions.oig.hhs.gov/ (the United States Department of Health and Human Services, Office of Inspector General's ["OIG"] List of Excluded Individuals/Entities);
- https://www.sam.gov/SAM/pages/public/searchRecords/advancedPIRSearch.jsf (the General Service Administration's System for Award Management); and
- https://omig.ny.gov/medicaid-fraud/medicaid-exclusions (the New York State Medicaid Exclusions List, available on the New York State Office of the Medicaid Inspector General's ["OMIG"] website).

Other sources and lists may also be checked as the Agency deems necessary and appropriate. For example, if a potential Staff member's resume or application indicates that he or she worked in a state(s) other than New York, the equivalent state-specific lists, if available, should also be checked. Should any questions arise about the need or advisability of consulting any sources of information in addition to the Exclusion Lists, they should be promptly directed to the Agency's Compliance Officer and appropriate compliance personnel.

## PROCEDURES

In order to ensure compliance with this Policy, the Agency will, at minimum, follow the procedures set out below.

### A. RESPONSIBILITY FOR SCREENING PROCESS

Initial screening of Staff prior to hiring (or rehiring) will be conducted by Human Resources. Nurse recruitment is responsible for performing exclusion checks. Screening of Referring Providers and Vendors will be conducted by the Agency's Compliance Officer or her designee(s). If a designee is used, the person/entity performing the required screenings on behalf of the Agency will report the results of all such screenings to, and will be supervised by, the Agency's Compliance Officer.

### B. PROCEDURES FOR SCREENING

**1.** Screening of Potential Staff Members, New Referring Providers and Potential Vendors.

**a.** Potential Staff Members. Every candidate to work as a Staff member at or on behalf of the Agency is required to disclose on his or her application form whether he or she is an Ineligible Person. In addition, at minimum, the Agency will also check the names of each potential Staff member against the Exclusion Lists *prior to* contracting with or employing the candidate or allowing them to volunteer at the Agency. If the candidate discloses that he or she is an Ineligible Person, fails to answer the question, appears on any of the

Exclusion Lists, or if there is any question as to whether he or she is an Ineligible Person, the procedures set out in section C, below, will be followed.

**b.** New Referring Providers. *Prior to* accepting referrals, filling orders or prescriptions from, or furnishing items or services at the medical direction of, a Referring Provider who is new to the Agency, the Agency will, at minimum, check the name of each such individual or entity against each of the Exclusion Lists. If the new Referring Provider appears on any of the Exclusion Lists, or if there is any question as to whether the individual or entity is an Ineligible Person, the procedures set out in section C, below, will be followed.

**c.** Potential Vendors. *Prior to* doing business with, or entering into a contract with, any potential Vendor to the Agency (including a Vendor that has previously been a Vendor to the Agency), the Agency will: (i) check the Vendor's name against each of the Exclusion Lists, and (ii) require the Vendor to check its employees and contractors against each of the Exclusion Lists, and confirm to the Agency that none of them appear on any of the Exclusion Lists. If either of these checks results in an Ineligible Person finding, or a question as to whether the Vendor or an individual or entity associated with the Vendor is an Ineligible Person, the procedures set out in section C, below, will be followed.

In addition, in order to help ensure that the Agency and its Vendors are in compliance with this Policy and Procedure, the Agency should, whenever possible, include in its written Vendor contracts/agreements provisions that provide for:

- A representation and warranty by the Vendor that it and its employees, contractors and Affected Individuals are not Ineligible Persons as of the date the contract/agreement is entered into;
- A representation and warranty by the Vendor that it will check each of the Exclusion Lists prior to hiring employees, contractors and Affected Individuals, and at least every month thereafter;
- The Vendor to maintain documentation for a defined period of time confirming that (i) it has performed the required checks of the Exclusion Lists and that such checks did not result in any Ineligible Person findings, and (ii) that it will make such documentation available to the Agency at its request;
- The Vendor to immediately disclose to the Agency's Compliance Officer if it, or any of its employees, contractor or Affected Individuals, becomes an Ineligible Person at any time during the term of the agreement/contract, or at any time thereafter; and
- Permitting the immediate termination of the agreement/contract and the Vendor's relationship with the Agency, if, at any time, the Vendor or any

of its employees, contractors or any Affected Individuals is found to be or becomes an Ineligible Person.

The Agency and the Compliance Officer may consult with outside counsel, as necessary and appropriate, in connection with these and other compliance-related contractual issues.

**2.** Regular Checks of Current Staff, Current Referring Providers and Current Vendors.

**a.** Checks At Least Every Month. The Compliance Officer or his/her designee will check the names of all current Staff, current Referring Providers and current Vendors against each of the Exclusion Lists at least every month. If an individual's or entity's name appears on any of the Exclusion Lists, the procedures set out in section C, below, will be followed.

**b.** Annual Certification by Current Staff. The Agency will also require each current Staff member to certify on his or her annual performance evaluation that he or she is not currently, and has not been at any time since the date of the last such certification, an Ineligible Person. If the Staff member discloses that he or she is an Ineligible Person or fails to answer the question, or if there is any question as to whether he or she is an Ineligible Person, the procedures set out in section C, below, will be followed.

## C. RESPONSE TO AN "INELIGIBLE PERSON" FINDING

Should the disclosure or review processes set forth above result in the determination that, or any question as to whether, any individual/entity may be, is, or has been, an Ineligible Person, then the following procedures will be followed:

**1.** Notification of Compliance Officer/Investigation/Preliminary Actions. The Compliance Officer will be immediately notified. An investigation into the matter will be promptly conducted, in conjunction with outside counsel as necessary and appropriate. The investigation will include a review of all relevant facts and circumstances. At minimum, during the pendency of any such investigation: (a) any Federal Health Care Program claims that are related (whether directly or indirectly) to the items or services provided by, at the medical direction of, or that result from an order, prescription or referral from, the individual/entity who is suspected to be an Ineligible Person, will be immediately suspended, and (b) a suspected Ineligible Person will be immediately removed from any and all responsibility for, and any and all involvement with, Federal Health Care Programs (including administrative and management services). The Agency may also take such other preliminary actions consistent with its Compliance Program and its compliance policies and procedures that it deems necessary and appropriate.

**2.** Finding of Ineligibility: Potential Staff Members, New Referring Providers and Potential Vendors. If, after the investigation is concluded, a potential Staff member, a new Referring Provider or a potential Vendor (or the potential Vendor's employee, contractor or any Affected Individual) is found to be an Ineligible Person, the Agency will not hire, contract or do business with, the individual or entity, and will not accept referrals, orders, prescriptions or direction from, any such Referring Provider. Other appropriate corrective action, if necessary, may also be taken in accordance with the Agency's Compliance Program and its compliance policies and procedures.

**3.** Finding of Ineligibility: Current Staff Members, Current Referring Providers and Current Vendors. If, after the investigation is concluded, a current Staff member, current Referring Provider or current Vendor (or the Vendor's employee or contractor) is found to be an Ineligible Person, the Agency will take all appropriate corrective action.

This may include, but is not limited to, one or more of the following: suspension or termination of an individual's employment or contract with, or work for, the Agency; termination of a Vendor's contract; permanent suspension of claims that are related (directly or indirectly) to the Ineligible Person; the timely return of monies improperly received, in accordance with applicable law, regulation, guidance and/or contract; and/or self-disclosure or reporting to the appropriate government agency(ies), or other payors, in accordance with applicable law, regulation, guidance and/or contract.

At minimum, an Ineligible Person will be removed from any and all responsibility for, and any and all involvement with, Federal Health Care Programs (including administrative and management services), and the Agency will cease submitting claims to, or seeking or causing payments to be made from, Federal Health Care Programs that relate in any way, whether directly or indirectly, to items or services provided by, at the medical direction of, or that result from an order, prescription, or referral from the Ineligible Person, in accordance with applicable law, regulation and guidance.

Other appropriate corrective action, if necessary, may also be taken in accordance with the Agency's Compliance Program and its compliance policies and procedures.

The Agency may consider reinstating an Ineligible Person only following confirmation that the individual/entity has been reinstated into the applicable Federal Health Care Program(s) and that the individual/entity is no longer an Ineligible Person. Any decision regarding reinstatement will be made in the Agency's sole discretion.

## D. MAINTENANCE OF DOCUMENTATION

The search results page of the checks of the Exclusion Lists or other proof that the required checks of the Exclusion Lists have been performed will be maintained by the Compliance Officer or his/her designee. In addition, records of any investigations, corrective action, disciplinary action or other action taken in accordance with this Policy and Procedure will also be maintained by the Compliance Officer or his/her designee. All such documentation will be maintained for no less than ten (10) years from the later of: (a) the last date on which the Exclusion Lists were searched, (b) the conclusion of the investigation, (c) the imposition or ending date (as the case may be) of any corrective, disciplinary or other action, or (d) for such longer period of time as may be required by applicable law, regulation or contractual requirement.

# D4: Compliance Reviews of Clinical Staff Credentials

## POLICY

The Agency is committed to ensuring that all Affected Individuals employed by, or who contract with, us have the proper credentials, experience and expertise required to discharge their responsibilities. To this end, the Agency is committed to using good faith efforts to not employ or contract with New York physicians/practitioners or licensed professionals who are not currently licensed and registered with the State (or who do not have the required credentials).

## PROCEDURES

In order to ensure compliance with the above Policy Statement, the Agency will, at minimum, take the following actions:

**A.** New Employees/Contractors. Before hiring or retaining any physician/ practitioner or other licensed professional, the Agency will appropriately query available websites, including, but not limited to (as applicable):

**1.** http://www.op.nysed.gov/opsearches.htm#
(links to the NY State Education Department's web page for license or certification verification);

**2.** http://www.op.nysed.gov/opd/
(links to the NY State Education Department's web page for disciplinary action against professional licensees); and

**3.** http://www.health.ny.gov/professionals/doctors/conduct/
(links to the NY Office of Professional Medical Conduct's webpage for disciplinary action against Physicians and Physician Assistants);

Other available information or resources may also be used from time-to-time, as necessary and appropriate.

**B.** Annual Reviews. Appropriate website searches (and/or searches/diligence of other appropriate information or resources) will be performed no less than annually on all Affected Individuals then employed by, or contracted with, the Agency. In addition, the Agency will require each current physician/practitioner or licensed professional to certify that: (a) he or she has not been convicted of a crime; and (b) that their New York State license and registration (or other required credentials) to practice their profession are current.

**C.** Corrective Action. Should the Agency determine that: (a) any Affected Individual is or has been convicted of a crime; or (b) that an Affected Individual's New York State

license and/or registration (or other required credentials) is not current, then the following action will be taken.

- First, the Compliance Officer will be immediately notified.
- Second, if the determination relates to an Affected Individual that has an existing relationship with the Agency, the Affected Individual will be immediately suspended from providing any services to, or on behalf of, the Agency (including, but not limited to, patient care services) pending the outcome of the investigation provided for below. In addition, any billing by, or related directly or indirectly to, that individual will be immediately suspended.
- Third, an investigation of the matter will be immediately undertaken (with the assistance of compliance counsel, as necessary), and appropriate corrective and disciplinary action will be promptly implemented in accordance with our Compliance Program (including, but not necessarily limited to, and as appropriate the return of monies improperly received and the termination of the relationship).
- Fourth, if the determination relates to an Affected Individual that does not have an existing relationship with the Agency, that person will not be hired or retained, or otherwise become affiliated with the Agency.

**D.** Documentation Retention. Records of the above reviews and any investigations, corrective action and/or disciplinary action taken will be maintained in the Affected Individual's personnel file or in another appropriate file for at least ten (10) years.

# D5: Compliance with Anti-Referral Laws

## POLICY

It is the policy of the Agency that all personnel shall comply with applicable Federal and State Anti-Referral laws and related regulations. The Agency has instituted various procedures to ensure compliance with these laws and to assist the Agency in preventing fraud, waste and abuse in Federal health care programs.

## A. OVERVIEW OF THE FEDERAL ANTI-REFERRAL LAWS

**1.** The Federal Anti-Kickback Statute. Under the Federal Anti-Kickback Statute, it is a crime to knowingly and willfully solicit, receive, offer or pay any remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind: (i) in return for or to induce the referral of an individual for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or (ii) in return for or to induce the purchasing, leasing, ordering or arranging (or the recommending of such) of any good, facility, item or service for which payment may be made in whole or in part under a federal health care program. "Federal health care program" under this statute generally includes ***all*** health care programs that receive ***any*** funding from the United States government (including, but not limited to, Medicare and Medicaid), as well as certain specified State health care programs.

The Federal Anti-Kickback Statute has been broadly interpreted by a number of courts to prohibit remuneration which is offered or paid when the circumstances show that ***one*** purpose of the arrangement is to induce referrals or otherwise engage in the prohibited conduct — ***even if*** the arrangement has other, wholly legitimate, business aspects to it.

There are, however, a number of statutory exceptions as well as a series of regulatory "safe harbors" under the Federal Anti-Kickback Statute. If an arrangement meets every requirement of an applicable exception or "safe harbor" it will be protected from prosecution under the statute. On the other hand, the failure of an arrangement to fit squarely within a safe harbor or exception does not necessarily render the arrangement illegal *per se* or otherwise actionable. Instead, in such cases, the arrangement will be analyzed in light of the governing law and regulations and, in particular, the intent of the parties (i.e., whether the arrangement is intended to induce referrals or otherwise violate the law).

Violation of the Federal Anti-Kickback Statute may result in significant fines (up to $100,000) and/or imprisonment (of up to ten years) for ***both sides*** of an illegal kickback arrangement. In addition, substantial civil monetary penalties and exclusion from Federal

and State health care programs may also result from violations of the Federal anti-kickback statute.

**2.** The Federal "Stark" Law. In general terms, the Federal "Stark" law prohibits a physician from making a referral to an entity for certain specified "designated health services" that are paid for by Medicare[2] to an entity when the physician (or his or her immediate family member) has a "financial relationship" (that is, an ownership interest, an investment interest or a compensation relationship) with that entity, unless an exception to the law is squarely met. If the referral is prohibited, so too is the submission of a claim for payment by the entity that receives the prohibited referral.

Currently, the Federal "Stark" law covers the following "designated health services": (a) Clinical laboratory services; (b) Physical therapy services; (c) Occupational therapy services; (d) Radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; (e) Radiation therapy services and supplies; (f) Durable medical equipment and supplies; (g) Parenteral and enteral nutrients, equipment, and supplies; (h) Prosthetics, orthotics, and prosthetic devices and supplies; (i) Home health services; (j) Outpatient prescription drugs; (k) Inpatient and outpatient hospital services; and (l) Outpatient speech-language pathology services.

In addition to the conduct directly prohibited by the law, the statute also prohibits "circumvention schemes," i.e., those arrangements that are designed to obtain referrals indirectly that cannot be made directly.

The Federal "Stark" law contains a number of statutory exceptions. In addition, there are also a series of regulatory exceptions to the "Stark" law. A number of the "Stark" exceptions are similar (but not identical) to the Federal Anti-Kickback "Safe Harbors."

Unlike the Federal Anti-Kickback Statute, however, if the Federal "Stark" law is implicated, all relevant exceptions must be squarely met, or the law will have been violated. The Federal "Stark" law is a "strict liability" law. In other words, unlike with the Federal Anti-Kickback Statute, the intent of the parties is irrelevant from a "Stark" perspective.

The penalties for violating the Federal "Stark" law include: (i) the denial of, or the requirement to refund, any payments for services that resulted from an unlawful referral; (ii) civil monetary penalties of up to $15,000 for each service for which a person presents

[2] On its face, the Federal "Stark" law only prohibits referrals for "designated health services" that are paid for by Medicare. However, the Social Security Act prohibits any Federal financial participation payment to a State for "designated health services" furnished on the basis of a referral that would result in a denial of payment under Medicare if Medicare covered the services in the same way as the State plan. In other words, arrangements that would be improper under the Federal "Stark" law may extend to State Medicaid Programs and prevent the State from receiving Federal matching funds for those services.

or causes to be presented a bill or claim that they know or should know results from a prohibited referral, or for which a required refund has not been made,[3] plus assessments of up to three times the amount claimed in lieu of damages; and (iii) exclusion from the Medicare and Medicaid programs as well as other Federal and/or State health-care programs.

## B. OVERVIEW OF RELEVANT STATE ANTI-REFERRAL LAWS

**1.** New York's Anti-Kickback Statute. Similar to the Federal law, New York State also makes it a crime to offer, agree to give or give any payment or other consideration in any form to another person to the extent such payment or other consideration is given: (i) for the referral of services for which payment is made under the Medicaid Program; or (ii) to purchase, lease or order any good, facility, service or item for which payment is made under the Medicaid Program. Medicaid providers who violate this statute may be found guilty of a misdemeanor crime punishable by fines of up to $10,000, or imprisonment for up to one year or both; except that Medicaid providers that violate this statute and obtain money or property having a value in excess of $7,500 may be found guilty of a class E felony.

**2.** The New York State "Stark" Law (the "Health Care Practitioners Referrals" Law). In New York State, a practitioner may not make a referral to a health care provider for clinical laboratory services, pharmacy services, radiation therapy services, x-ray or imaging services or physical therapy services if the practitioner or a member of his immediate family has a financial relationship (including an ownership interest, an investment interest or a compensation arrangement) with that provider, unless a statutory or regulatory exception is met (and again, there are a number of varied exceptions that exist).

Unlike its Federal counterpart, the New York State Stark law covers all payers. If the referral is prohibited, so too is any demand for payment. The New York State "Stark" law also covers any cross-referral scheme designed to make referrals indirectly that could not be made directly. A provider or practitioner that collects any amount under a prohibited referral is jointly and severally liable to the payer. In addition, disciplinary action (including license revocation) by the appropriate State licensing authority is also a possibility. As with the Federal "Stark" law, if the New York State "Stark" law is implicated, all applicable exceptions must be met, or the law will have been violated (i.e., it, too is a "strict liability" law and the intent of the parties is irrelevant).

[3] Administrative penalties under the Civil Monetary Penalties Law may be imposed by the Federal Office of Inspector General. These penalties are subject to adjustments for inflation and have increased to $27,750, for each service, as of March 17, 2022. For "circumvention schemes," a civil monetary penalty of up $185,009 (as of March 17, 2022) may be imposed on any physician or entity that knows or should know that the scheme/arrangement has a principal purpose of assuring referrals by the physician to a particular entity that could not be directly made under the law.

## C. COMPLIANCE WITH ANTI-REFERRAL LAWS

It is the Agency's intent to at all times comply with the anti-referral laws to which it is subject. Given the complexity of these laws, outside counsel will be consulted as necessary to ensure the Agency's on-going compliance.

The decision to refer a patient is a separate and independent clinical decision made by the referring physician or practitioner. The Agency will not knowingly and willfully offer, pay, solicit or receive remuneration to induce or reward the referral of business reimbursable under any Federal or State health care program. Nor will the Agency otherwise engage in any relationship or arrangement that violates the anti-referral laws. Moreover, it is the Agency's policy to avoid relationships or arrangements that create an appearance of illegality or impropriety.

1. Marketing Activities. All marketing activities and advertising by the Agency personnel must be based on the merits of the services provided and *not* on any promise, express or implied, of remuneration for referrals. In addition, all marketing activities and advertising must be truthful and not misleading, and must be supported by evidence to substantiate any claims made and must comply with all applicable legal requirements. The Agency's best advertisement is the quality of the medical services we provide. The Agency personnel should not disparage the services or business of a competitor through the use of false or misleading representations. All marketing materials must be reviewed and approved by the Compliance Officer before they are disseminated. The Compliance Officer may consult with legal counsel, as necessary and appropriate.

## D. QUESTIONS

To the extent that you have any questions regarding the propriety of an existing or prospective arrangement or relationship (whether under the laws discussed herein, under our compliance policies, or otherwise), you are encouraged to contact the Agency's Compliance Officer, *(see compliance poster for updated information)*. She may be reached by email at *(see compliance poster for updated information)* or by telephone at *(see compliance poster for updated information)*. In addition, compliance concerns may be submitted via the Compliance Hotline at *(See compliance poster for updated information)*.

# D6: Compliance with Federal and State False Claims Laws: Overview of the Laws Regarding False Claims and Whistleblower Protections

## BACKGROUND/PURPOSE

The Agency is committed to complying with the requirements of Section 6032 of the Federal Deficit Reduction Act of 2005, and preventing and detecting any fraud, waste, or abuse. To this end, the Agency maintains a Compliance Program and strives to educate its work force on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments. The Agency has instituted various procedures, which are set forth in our Compliance Manual and various Compliance Program policies and procedures, to ensure compliance with these laws and to assist us in preventing fraud, waste and abuse in Federal health care programs. In furtherance of this policy and to comply with the Deficit Reduction Act, the Agency disseminates this policy to all personnel (including management, contractors and other agents) to ensure that such persons are aware of certain relevant Federal and State laws, and that submission of a false claim can result in significant administrative and civil penalties under the Federal False Claims Act and other Federal and New York State laws.

## POLICY

To assist the Agency in meeting its legal and ethical obligations, any personnel who reasonably suspects or is aware of the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse related to a Federally or State funded health care program is required to report such information to the Compliance Officer. Any personnel who report such information will have the right and opportunity to do so anonymously and will be protected against retaliation and intimidation for coming forward with such information both under our internal Compliance Program policies and procedures and Federal and State law. However, the Agency retains the right to take appropriate action against any personnel who has participated in a violation of Federal or State law or the Agency's Compliance Program.

The Agency is committed to investigating any suspicions of fraud, waste, or abuse swiftly and requires all personnel to assist in such investigations. Corrective action will be promptly and thoroughly implemented, as necessary and appropriate. Failure to report or assist in an investigation or resolution of fraud and abuse is a breach of the personnel's obligations to the Agency and may result in disciplinary action, up to, and including termination of employment or affiliation with the Agency.

## RELEVANT LAWS:

### I. FEDERAL LAWS

#### A. <u>The Federal False Claims Act (31 USC §§ 3729-3733)</u>

The False Claims Act ("FCA") provides, in pertinent part, as follows:

**§ 3729. False claims**

**a. Liability for certain acts.**

1. **In General** – Subject to paragraph (2), any person who -
   - Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
   - Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
   - Conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
   - Has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
   - Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
   - Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or
   - Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461) [1] plus 3 times the amount of damages which the Government sustains because of the act of that person.

2. **Reduced Damages** - If the court finds that -
   - The person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;
   - Such person fully cooperated with any Government investigation of such violation; and (C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or

[1] Although the statutory provisions of the Federal False Claims Act authorizes a range of penalties of from between $5,000 and $10,000, those amounts have been adjusted for inflation and increased by regulation to not less than $11,803 and not more than $23,607 for penalties assessed after December 13, 2021, whose associated violations occurred after November 2, 2015. *See 28 C.F.R. §85.5*.

administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

3. **Costs Of Civil Actions** - A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

**b. Definitions -** For purposes of this section -

**1.** The terms "knowing" and "knowingly" –

**A.** Mean that a person, with respect to information -

- Has actual knowledge of the information;
- Acts in deliberate ignorance of the truth or falsity of the information; or
- Acts in reckless disregard of the truth or falsity of the information; and

**B.** Require no proof of specific intent to defraud;

**2.** The term "claim" -

**A.** Means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that -

- Is presented to an officer, employee, or agent of the United States; or
- Is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—
  - Provides or has provided any portion of the money or property requested or demanded; or
  - Will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

**B.** Does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

**3.** The term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

**4.** The term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

**c.** Exemption from disclosure.--Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

**d.** Exclusion.--This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government, or submits a claim to entities administering government funds that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital which obtains interim payments from Medicare or Medicaid throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare or Medicaid program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "qui tam relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

## B. Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801–3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, the agency receiving the claim may impose a penalty of up to $5,000 for each claim.[2] The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted rather than when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

## II. NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

### A. Civil and Administrative Laws

#### 1. NY False Claims Act (State Finance Law, §§187–194)

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is equal to the amount that may be imposed under the federal FCA (as may be adjusted for inflation) and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit or 15-25% if the government did participate in the suit.

#### 2. Social Services Law §145-b -- False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the local Social Services district may recover three times the amount

[2] Although the statutory provisions of the Program Fraud Civil Remedies Act authorize a penalty up to $5,000, that amount has been adjusted for inflation and increased by regulation to not more than $11,803 for penalties assessed after December 13, 2021, whose associated violations occurred after November 2, 2015. *See 28 C.F.R. §85.5.*

incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to ten thousand dollars per violation. If repeat violations occur within five years, a penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

3. **Social Services Law § 145-c – Sanctions**
   If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

## B. Criminal Laws

1. **Social Services Law §145 – Penalties**
   Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2. **Social Services Law § 366-b – Penalties for Fraudulent Practices**
   - **a.** Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.
   - **b.** Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

3. **Penal Law Article 155 – Larceny**
   The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.
   - **a.** Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.

**b.** Third degree grand larceny involves property valued over $3,000. It is a Class D felony.

**c.** Second degree grand larceny involves property valued over $50,000. It is a Class C felony.

**d.** First degree grand larceny involves property valued over $1 million. It is a Class B felony.

**4. <u>Penal Law Article 175 – False Written Statements</u>**

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

**a.** § 175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.

**b.** § 175.10, Falsifying business records in the first degree includes the elements of the § 175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

**c.** § 175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.

**d.** § 175.35, Offering a false instrument for filing in the first degree includes the elements of the second-degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

**5. <u>Penal Law Article 176 – Insurance Fraud</u>**

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

**a.** Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

**b.** Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.

**c.** Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.

**d.** Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.

**e.** Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.

**f.** Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

**6. <u>Penal Law Article 177 – Health Care Fraud</u>**

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

**a.** Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.

**b.** Health care fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.

**c.** Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

**d.** Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.

**e.** Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

## III. WHISTLEBLOWER PROTECTIONS

### A. Federal False Claims Act (31 U.S.C. §3730[h])

The Federal False Claims Act provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

### B. NY False Claim Act (State Finance Law §191)

The New York State False Claim Act also provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

### C. New York Labor Law §740

Labor Law Section 740 prohibits the taking of "retaliatory" action by an employer against an employee (including former employees and natural persons working as independent contractors), whether or not the employee is acting within the scope of his or her job duties, because the employee does any of the following:

**a.** Discloses or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in

violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety; [3]

**b.** Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such activity, policy or practice by such employer; or

**c.** Objects to, or refuses to participate in, any such activity, policy or practice.

Under Section 740, "retaliatory action" is defined to mean an adverse action taken by an employer or his or her agent to discharge, threaten, penalize, or in any other manner discriminate against any employee or former employee exercising his or her rights under Section 740. This includes: (i) adverse employment actions or threats to take such adverse employment actions against an employee in the terms of conditions of employment (including but not limited to discharge, suspension, or demotion); (ii) actions or threats to take such actions that would adversely impact a former employee's current or future employment; or (iii) threatening to contact or contacting United States immigration authorities or otherwise reporting or threatening to report an employee's suspected citizenship or immigration status or the suspected citizenship or immigration status of an employee's family or household member.

If an employer takes a retaliatory action against the employee, the employee may bring a civil action within two years after the alleged retaliatory action was taken. The parties to such an action are entitled to a jury trial. A court may order: an injunction to restrain continued violation of the law; the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or "front pay;" the reinstatement of full fringe benefits and seniority rights; the compensation for lost wages, benefits and other remuneration; the payment by the employer of reasonable costs, disbursements and attorneys' fees; a civil penalty not to exceed $10,000; and/or the payment by the employer of punitive damages, if the violation was willful, malicious or wanton.

## D. New York Labor Law §741

Labor Law Section 741 prohibits certain defined health care employers from taking "retaliatory action" against an employee because the employee does any of the following:

**a.** discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or

**b.** objects to, or refuses to participate in, any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

[3] The employee's disclosure under this provision will only be protected if the employee first made a good faith effort to notify his or her employer.

Section 741 defines "retaliatory action" to mean the discharge, suspension, demotion, penalization or discrimination against an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

An employee will not be protected under Section 741 unless he or she has brought the improper quality of patient care or improper quality of workplace safety to the attention of a supervisor and has afforded the employer a reasonable opportunity to correct the activity, policy or practice.

However, such notice and opportunity to correct is not required in connection with disclosures or threats to disclose an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety where it presents an imminent threat to public health or safety or to the health of a specific patient or specific health care employee and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

The same relief and enforcement provided for under Labor Law Section 740 (described above) are applicable to retaliatory actions under Section 741.

# D7: Gifts and Benefits

## POLICY

Affected Individuals [1] of the Agency may not engage, either directly or indirectly, in any corrupt business practice, including bribery, kickbacks or payoffs, intended to influence or reward favorable decisions of any patient, physician/practitioner, government representative, contractor, vendor, or any other person in a position to benefit the Agency or its employees.

Personnel are strictly prohibited from soliciting any gift or benefit, either individually or on behalf of the Agency. In addition, Affected Individuals may not offer, pay or receive any gifts or benefits to or from any person or entity: (i) that makes referrals to us, (ii) to which we make referrals, or (iii) with which we do business, under circumstances where the gift or benefit is offered, paid or received with a purpose of inducing or rewarding referrals of health care items or services, or other business between the parties. Affected Individuals are strictly prohibited from offering or giving any gifts or benefits to government employees or officials.

The guiding principle of this Policy is simple: Affected Individuals may not be involved with gifts or benefits that are undertaken: (i) in return for or to induce referrals, or (ii) in return for or to induce the purchasing, leasing, ordering or arranging (or the recommending of any of the foregoing) of any item or service.

This Policy applies to our interactions with providers who refer patients to us or to which we make referrals, and to our interactions with our vendors (including, but not limited to, medical supply companies from which we purchase). This Policy also applies to patients and potential patients.

For the purposes of this Policy, "gifts and benefits" include, but are not limited to, anything of value provided at no charge or at a discount. This includes, but is not limited to: cash, cash equivalents (e.g., checks, gift certificates, and stocks), prizes, meals, artwork, tickets to sporting or entertainment events, and sponsorship of recreational or social activities.

This Policy does not preclude the acceptance of items of nominal value, which are clearly tokens of friendship or business hospitality, such as fruit, cookies or candy that a vendor may provide during the holiday season that are shared among staff.

Gifts or benefits to spouses or immediate family members of Affected Individuals are not permitted. "Immediate family members" for purposes of this Policy includes any of the following: your husband or wife; birth or adoptive parent, child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

[1] "*Affected Individuals*" means all persons who are affected by the Practice's "risk areas," including our employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.

**PROCEDURE**

To the extent that you have any question or concern regarding the applicability of this Policy to a particular circumstance, you are required to contact the Compliance Officer.

A failure to follow this Policy may result in disciplinary action in accordance with the terms of our Compliance Program.

# D8: Non-Retaliation, Non-Intimidation for Participation in the Compliance Program

## POLICY

The purpose of this Policy is to ensure that all personnel understand the Agency's or the "Organization's" commitment to prohibiting intimidation, retaliation, harassment and discrimination for "good faith participation in the Compliance Program" (as defined below).

Intimidation or retaliatory action in any form by any individual associated with the Agency is strictly prohibited and is itself a serious violation of the Code of Conduct and this Policy. This includes, but is not limited to, any adverse employment action and any other negative treatment, resulting from good faith participation in the Compliance Program.

## PROCEDURES

### A. Oversight of This Policy

The adoption and implementation of, and compliance with, this Policy shall be overseen by the Board of Directors, with the Audit Committee assisting the Board in fulfilling its responsibilities. The Board may, in its discretion, authorize certain functions relating to the implementation of, and compliance with, this Policy to be performed by one or more employees, officers or directors, but the Board will, at all times, retain overall responsibility for all aspects of the oversight of this Policy. The Compliance Officer has been designated by the Board to administer this Policy and report to the Audit Committee on issues related to this Policy.

### B. Participation in the Compliance Program

"Good faith participation in the Compliance Program" includes, but is not limited to:

- Reporting actual or potential issues or concerns, including but not limited to, any action or suspected action taken by or within the Agency that is illegal, fraudulent or in violation of any adopted Agency policy to appropriate personnel (as indicated below);
- Cooperating with or participating in the investigation of potential compliance issues;
- Assisting with or participating in self-evaluations, audits, and/or implementation of remedial actions;
- Reporting instances or intimidation or retaliation; or

- Reporting potential fraud, waste or abuse to the appropriate State or Federal entities, including the appropriate regulatory officials as provided in New York Labor Law §§ 740 and 741.[1]

**C. Reporting And Confidentiality**

As required by the Agency's Compliance Program, all Affected Individuals are expected to report suspected misconduct or possible violations of the Compliance Program to the Compliance Officer, at the phone number or e-mail address below. Affected Individuals may also report compliance issues or concerns to the Compliance Hotline at *(See compliance poster for updated information)*. Affected Individuals may report compliance issues or concerns anonymously, if they choose (by way of the Hotline or otherwise).

If you report compliance issues, your identity will be kept confidential, whether requested or not, unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding.

| **Compliance Program Contact Information** | |
|---|---|
| **Compliance Officer**<br>*(see compliance poster for updated information)* | Ph: *(see compliance poster for updated information)*<br>Email: *(see compliance poster for updated information)* |
| **Compliance Hotline** | Ph: *(See compliance poster for updated information)* |

**A. Investigation of Intimidation / Retaliation Complaints**

- All allegations of intimidation or retaliation for good faith participation in the Compliance Program will be promptly investigated. The Compliance Officer, or designee, will oversee the investigation and take all necessary and appropriate actions. The Compliance Officer, or designee, will be assisted by internal staff and/or may solicit the support of external resources (including counsel), as necessary and appropriate.
- All individuals who may have relevant information will be promptly interviewed. At the outset of the interview process, the interviewee will be reminded that retaliation and intimidation is unlawful and a violation of the Agency's Code of Conduct. The interviewee will also be reminded of the Agency's disciplinary policy regarding failure to cooperate (See the "Protocols for Investigations and Implementing Corrective Action, Including Discipline").

[1] For a brief summary of New York Labor Law §§ 740-741, as of February 2023, please see the appendix to this Policy.

- All documentation related to the investigation will be kept secured in a central location under the control of the Compliance Officer or designee. Such investigative files will be kept separate from Personnel files.
- If the Compliance Officer determines that an individual was improperly intimidated or retaliated against for good faith participation in the Compliance Program, the Agency will, in accordance with the Agency's Compliance Program, take all appropriate corrective action as to the individual who was intimidated or retaliated against, subject to the oversight of the Board.
- In addition, if the Compliance Officer determines that an individual was intimidated or retaliated against for good faith participation in the Compliance Program, appropriate disciplinary action will be taken against the offending person, in accordance with the Agency's Compliance Program, subject to the oversight of the Board.
- The Agency may terminate contracts and affiliations as a result of retaliation or intimidation.
- In order to prevent retaliation or intimidation against employees who in good faith participate in the Compliance Program, all terminations of employment must be approved by the Director of Human Resources, in consultation with the Chief Executive Officer, prior to being effectuated. Director of Human Resources, in consultation with the Chief Executive Officer must be advised of the employee's participation in the Compliance Program prior to the termination decision or other adverse employment action being made.
- A person that is subject of a whistleblower complaint may not be present at or participate in Board or Committee deliberations or vote on the matter relating to such complaint. The Board or designated Committee, in its discretion, may request that a person who is subject of a whistleblower complaint present information as background or answer questions at a Board or Committee meeting prior to the commencement of deliberations or related voting.

**B. Reporting to the Governing Body**

The Compliance Officer will advise the Audit Committee regarding any alleged acts of retaliation or intimidation in violation of this Policy on an on-going basis.

**C. Distribution of Policy**

This Policy shall be distributed to all Affected Individuals (including directors, officers and employees), and to volunteers who provide substantial services to the Agency.

## APPENDIX:

## A BRIEF SUMMARY OF NEW YORK LABOR LAW SECTIONS 740 & 741[2,3]

New York Labor Law Sections 740 and 741 are laws that provide protection to "whistleblowers" in certain cases. This Appendix provides a brief summary of these laws. Full copies of Sections 740 and 741 are posted in a prominent position in the Agency's front entrance.

### New York Labor Law Section 740

Section 740 prohibits the taking of "retaliatory action" by an employer against an employee (including former employees and natural persons working as independent contractors), whether or not the employee is acting within the scope of his or her job duties, because the employee does any of the following:

- **a.** Discloses or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety;
- **b.** Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such activity, policy or practice by such employer; or
- **c.** Objects to, or refuses to participate in, any such activity, policy or practice.

Under Section 740, "retaliatory action" is defined to mean an adverse action taken by an employer or his or her agent to discharge, threaten, penalize, or in any other manner discriminate against any employee or former employee exercising his or her rights under Section 740. This includes: (i) adverse employment actions or threats to take such adverse employment actions against an employee in the terms or conditions of employment (including but not limited to discharge, suspension, or demotion); (ii) actions or threats to take such actions that would adversely impact a former employee's current or future employment; or (iii) threatening to contact or contacting United States immigration authorities or otherwise reporting or threatening to report an employee's suspected citizenship or immigration status or the suspected citizenship or immigration status of an employee's family or household member to a federal, state, or local agency.

### Conditions and Exceptions Under New York Labor Law Section 740

An employee's disclosure to a public body of an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety will not be protected under Section 740 unless the employee has made a good faith effort to notify his or her employer. Specifically, when such notice is required, the employee is required to bring the

[2] This Appendix is not intended to be a comprehensive description of the law, a legal interpretation or legal advice.

activity, policy or practice to the attention of a supervisor of the employer and to afford the employer a reasonable opportunity to correct it.

However, such employer notification is not required where:

**a.** There is an imminent and serious danger to the public health or safety;
**b.** The employee reasonably believes that reporting to the supervisor would result in a destruction of evidence or other concealment of the activity, policy or practice;
**c.** Such activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor;
**d.** The employee reasonably believes that reporting to the supervisor would result in physical harm to the employee or any other person; or
**e.** The employee reasonably believes that the supervisor is already aware of the activity, policy or practice and will not correct it.

## New York Labor Law Section 741

Section 741 prohibits certain defined health care employers from taking "retaliatory action" against an employee because the employee does any of the following:

**a.** Discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or
**b.** Objects to, or refuses to participate in, any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

Section 741 defines "retaliatory action" to mean the discharge, suspension, demotion, penalization or discrimination against an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

## Conditions and Exceptions Under New York Labor Law Section 741

An employee will not be protected under Section 741 unless he or she has brought the improper quality of patient care or improper quality of workplace safety to the attention of a supervisor and has afforded the employer a reasonable opportunity to correct the activity, policy or practice.

However, such notice and opportunity to correct is not required in connection with disclosures or threats to disclose an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety where it presents an imminent threat to public health or safety or to the health

of a specific patient or specific health care employee and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

## Relief/Enforcement Under Both New York Labor Law Sections 740 and 741

Under both Sections 740 and Section 741, an employee who has been the subject of retaliatory action in violation of the law may bring a civil action within two years after the alleged retaliatory action was taken. The parties to such an action are entitled to a jury trial.

In connection with such an action, a court may order: an injunction to restrain continued violation of the law; the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or "front pay"; the reinstatement of full fringe benefits and seniority rights; the compensation for lost wages, benefits and other remuneration; the payment by the employer of reasonable costs, disbursements and attorneys' fees; a civil penalty not to exceed $10,000; and/or the payment by the employer of punitive damages, if the violation was willful, malicious or wanton.

Under both Sections 740 and 741, it is a defense that the retaliatory action was predicated on grounds other than the employee's exercise of the rights that these sections of the law protect.[4]

[4] Under Section 740, a court may also order that reasonable attorneys' fees and court costs and disbursements be awarded to an employer if the action the employee brings is without basis in law or fact.

# D9: Conflict of Interest and Related Party

## POLICY

This Conflicts of Interest and Related Party Transactions Policy is part of the Agency's compliance program. The Agency requires that its Members of the Board of Directors, officers, employees, and volunteers serving on any advisory boards or stewardship committees relating to any entity associated with the Agency or its affiliates (the "Covered Group") avoid any conflict of interest or the appearance of a conflict of interest and comply with all applicable legal requirements, including but not limited to, the requirements concerning Related Party Transactions.

The Covered Group must, at all times, act fairly, reasonably and in the Agency's best interests, and must refrain from personal considerations of any kind that conflict with, or that give rise to, or appear to give rise to, an actual or potential conflict of interest between the Covered Group Member's interest and the best interests of the Agency or its service recipients. The Agency strives to avoid conflicts of interest, or the appearance thereof, in its relationships with others.

It is expected that the Covered Group read, understand and comply with this Policy. Failure to comply with this policy may constitute grounds for removal of the individual from his or her position or for other appropriate disciplinary action (subject to any applicable collective bargaining agreements).

This policy supplements but does not replace any applicable state laws governing conflict of interest. This policy is intended to ensure fair and ethical behavior in connection with our transactions.

There are a number of key words and phrases used throughout this Policy. For your convenience, they are defined in the Appendix that may be found at the end of this document.

## OVERSIGHT OF THIS POLICY

The adoption, implementation of and compliance with this Policy shall be overseen by the Board of Directors, with the Audit Committee assisting the Board in fulfilling its responsibilities as more fully detailed below. The Board may, in its discretion, authorize certain functions relating to the implementation of, and compliance with, this Policy to be performed by one or more authorized individuals, but the Board shall, at all times, retain overall responsibility for all aspects of the oversight of this Policy.

## PROCEDURES FOR DISCLOSURE AND REVIEW

### 1. How and When to Disclose

**A.** ***Annual Written Conflict of Interest Disclosure Statement.*** The Covered Group will, at least annually, file a written Conflict of Interest Disclosure Statement with the designated

Compliance Officer. Compliance Officer will collect such Statements and will provide copies of all completed Statements to the Audit Committee. The Compliance Officer may also provide other relevant documents or information relating to the Statements. The Compliance Officer will maintain a record of all such Statements.

The Conflict of Interest Disclosure Statements will ask the Covered Group member to identify, to the best of their knowledge, at least the following: (a) any entity of which the member of the Covered Group is a director, trustee, member, owner, officer or employee, and with which the Agency has a relationship, and (b) any transaction in which the Agency is, or is contemplating becoming, a participant and in which the Covered Group member has a Disclosable Conflict of Interest.

**B.** ***Continuing Obligation to Update Conflict of Interest Disclosure Statement*.** Each member of the Covered Group has an affirmative obligation to update their annual written Conflict of Interest Disclosure Statement whenever there are new or changed facts or circumstances that create a Disclosable Conflict of Interest. All updates to the annual Conflict of Interest Disclosure Statement are to be filed with the Agency's Compliance Officer. The Compliance Officer or other Board designee will collect such updates and will provide copies thereof to the Chair of the Audit Committee. The Compliance Officer may also provide to the Chair other relevant documents and information relating to any matter(s) that are believed to present a Disclosable Conflict of Interest. The Compliance Officer will also maintain a record of all such updates.

**C.** ***Prior to the Initial Election of a Director.*** Prior to the initial election of any Director, the individual proposed for a Director position shall complete, sign and submit to the designated Compliance Officer a written Conflict of Interest Disclosure Statement identifying, to the best of the proposed Director's knowledge, any entity of which he or she is an officer, director, trustee, member, owner (either as a sole proprietor or a partner), or employee and with which the Agency has a relationship, and any transaction in which the Agency is a participant and in which the proposed Director might have a Disclosable Conflict of Interest. All such Statements will be filed with the designated Compliance Officer. Compliance Officer will collect such Statements and provide copies of each completed Statement to the Chair of the Audit Committee. The Compliance Officer may also provide other relevant documents or information relating to the Statements.

**2. The Review Process**.

**A.** ***Review by the Audit Committee***. All disclosures of matters that are believed to present a Disclosable Conflict of Interest will be forwarded by the Chair of the Audit Committee to the Audit Committee, along with other relevant documents and information relating thereto, if any, for its consideration in a manner consistent with applicable law.

The Audit Committee of the Board will conduct a full review of all matters that raise an actual or potential conflict of interest, or that create the appearance of an actual or potential conflict of interest. In so doing, the Audit Committee:

- Will consider all relevant facts and circumstances involved in the matter, and in particular, what is fair, reasonable and in the best interests of the Agency [and its patients];
- Will exclude the affected individual(s) from being present at or participating in the deliberations or voting on the matter;
- Will prohibit the affected individual(s) from any attempt to Improperly Influence the deliberations or voting on the matter; and
- Will permit the affected individual(s), upon request of the Audit Committee of the Board to present information as background or answer questions concerning the matter at a committee or board meeting prior to commencement of deliberations or voting on the matter.

**B.** ***Report to the Board of Directors***. The Audit Committee will make an initial determination as to whether a conflict of interest exists or may exist, and recommend what course the Agency should take in connection with the matter. The Compliance Officer and outside counsel, as needed, shall assist the Audit Committee in reporting its recommendations and findings to the entire Board of Directors. The Board of Directors shall review the recommendations and findings of the Audit Committee and make its findings which shall be final and binding.

The Board will contemporaneously document in writing in appropriate minutes of any meeting at which the matter is deliberated or voted upon all deliberations and determinations relating thereto, including, at a minimum, a summary of the matter, a summary of the deliberations, consideration of any alternatives, who is present at the meeting(s), the vote and the basis for the determination, including, but not necessarily limited to, whether the matter is as fair and reasonable to the Agency as would otherwise then be obtainable by the Agency.

**C.** **Corrective Actions.** If, after review and consideration, it is determined that a potential or actual conflict of interest does exist, then the Agency will implement the following corrective actions to protect the Organization's best interests:

1. **Generally**. Members of the Covered Group for whom an actual or potential conflict of interest is found to exist will take no part in consideration, deliberation or decision-making as to the underlying matter that is the subject of the potential conflict.
2. **Recusal**. The conflicted Member of the Covered Group must recuse him or herself from discussion (including informal discussions) of matters affected by the conflict of interest, including physical absence from discussions, deliberations, voting or decision making either during consideration by management or during Board or Board Committee meetings.

3. **Quorum**. A conflicted Director will not be counted in determining a quorum for any vote on the matter that is the subject of the potential conflict.
4. **Personal Influence**. The conflicted Member of the Covered Group will not use his or her personal influence – in any way or at any time - with respect to the matter that is the subject of the potential conflict.
5. **Significant Conflicts**. If the conflict is so significant as to be incompatible with the mission, strategic priorities, or best interests of the Agency, a determination will be made by the Board whether it is appropriate for the individual to continue serving on the Board, as a member of a Board committee, or as an Officer or Key Person of the Organization.

**D.** ***Additional Special Rules for Related Party Transactions and Member Related Party Transactions*.** In addition to the general considerations outlined above, all Related Party Transactions and Member Related Party Transactions are subject to the following additional special rules:

- The Agency may not enter into a Related Party Transaction unless the transaction is determined to be fair, reasonable and in the Agency's best interest at the time of the determination;
- In considering the Related Party Transaction, the Audit Committee shall ensure that the member of the Covered Group who has an interest in the Related Party Transaction has disclosed in good faith all material facts concerning such interest; and
- No Related Party may participate in the deliberations or voting relating to any Related Party Transaction in which he or she has an interest. However, the Audit Committee may request that a Related Party present information as background or answer questions concerning a Related Party Transaction at a Board or committee meeting prior to the commencement of deliberations or voting relating.

With respect to any Related Party Transaction involving the Agency and in which a Related Party has a substantial financial interest, the following shall also apply:

- Prior to entering into a Related Party Transaction or a Member Related Party Transaction in which a Related Party or a Member Related Party has a substantial financial interest, the Board of Managers must consider alternative transactions, to the extent available; and
- The Agency may not enter into a Related Party Transaction or a Member Related Party Transaction unless the transaction is determined to be fair, reasonable and in the Agency's best interest at the time the Agency enters into it, and the reasons for such determination must be contemporaneously documented.

**E.** **Certain Compensation Decisions**. Unless otherwise provided in the certificate of incorporation or the by-laws, the Board shall have the authority to fix the compensation of Directors for services in any capacity. The fixing of compensation of Officers, if not done in or pursuant to the by-laws, requires the affirmative vote of a majority of the

entire Board unless a higher proportion is set by the certificate of incorporation or by-laws. All compensation must be in a reasonable amount for services rendered and must be in compliance with all other legal requirements. No person who may benefit from such compensation may be present at or otherwise participate in any deliberation or vote concerning his or her compensation. However, such person may be asked to present information as background or answer questions at a meeting prior to the commencement of deliberations or voting relating thereto. The certificate of incorporation and by-laws must be reviewed to determine who has the authority to fix compensation of the Directors. A Director will not be prohibited from deliberating or voting concerning compensation for service on the Board that is to be made available or provided to all Directors of the Agency on the same or substantially similar terms.

**EXAMPLES**

It is not possible to list every circumstance that gives rise to either a conflict of interest or the appearance of a conflict of interest. However, the following examples may be helpful in illustrating the types of situations that may create an actual or potential conflict of interest or the appearance of one. Remember that this is not an exhaustive list, and your particular circumstance may very well give rise to a conflict of interest, or the appearance of one, even though it is not listed below.

There is a Disclosable Conflict of Interest if a member of the Covered Group or their Relative:

- Engages in, or intends to engage in, a Related Party Transaction;
- Has any financial interest in a vendor; is a member, owner, director, trustee or officer of a vendor; or has a contractual or employment relationship with a vendor;
- Has any financial interest in an entity that competes with the Agency, or has a contractual or employment relationship with an entity that competes with the Agency;
- Solicits or accepts any gifts, entertainment, or other favors from any Agency vendor, or an individual or entity seeking to become a vendor, under circumstances where it might be inferred that such action was intended to influence the member of the Covered Group in the performance of their duties on behalf of the Agency;
- Represents the Agency in any matter in which the person has a personal interest (financial or otherwise);
- Uses, or has the opportunity to use, knowledge about the Agency for personal gain, profit or advantage; or
- Might have, or appears to have, a conflicting interest in any transaction or arrangement in which the Agency is, or intends to be, a participant.

Note, however, that De Minimis Transactions and Ordinary Course of Business Transactions, as defined in the Appendix, are not covered by this Policy. Even in such cases, however, the affected party may not intervene or seek to influence the person tasked with making the decision or reviewing the transaction. Further, the person tasked with making the decision or reviewing the

transaction should not consider or be influenced by the affected party's involvement in decisions or matters that may affect the decision-maker/reviewer.

**TRAINING**

The Agency will conduct training and education for the Covered Group on this Policy, including as to what constitutes Disclosable Conflicts of Interest, required disclosures, when and how disclosures are to be made, the review and determination process and other related matters at the individual's orientation and on a regular basis thereafter.

* * *

If you are uncertain about a particular transaction or matter, it should be disclosed pursuant to this Policy.

## APPENDIX: DEFINITIONS

This Appendix sets forth the definitions of a number of important words and phrases that are used throughout this Policy.

1. **"Affiliate"**. An "Affiliate" of the Agency means any entity controlled by or in control of the Agency.

2. **"Board"**. "Board" means the body responsible for the management of the Agency including, but not limited to, board of directors or any other body constituting a Governing Board as defined below.

3. **"Covered Group"**. "Covered Group" means its Members of the Board of Directors, officers, employees, and volunteers serving on any advisory boards or stewardship committees relating to any entity associated with the Agency or its affiliates.

4. **"De Minimis Transaction"**. A "De Minimis Transaction" for purposes of this Policy is one that is immaterial or insignificant to the Agency, taking into account all relevant factors, including but not limited to: (i) the Agency's overall business or financial operations; (ii) any impact the transaction might have on the quality of care, treatment or services provided to our patients; and/or (iii) the size and scope of the particular transaction.

5. **"Director"**. "Director" means any member of the Governing Board of the Agency, whether designated as director, trustee, manager, governor, or by any other title.

6. **"Disclosable Conflict of Interest"**. "Disclosable Conflict of Interest" means any circumstance that gives rise to, or appears to give rise to, an actual or potential conflict of interest between a Covered Group member's interest (or the personal, business or financial interests of a Relative of a Covered Group member) and the best interests of the Agency. In addition, every Related Party Transaction and every Member Related Party Transaction is a Disclosable Conflict of Interest.

7. **"Improperly Influence"**. "Improperly Influence" means coercing, manipulating, misleading, or fraudulently influencing the decision-making when the Covered Group members knew or should have known that their action, if successful, could result in the outcome which they could not deliberate or vote on directly.

8. **"Independent Director"**. "Independent Director" means a director who: (i) is not, and has not been within the last three years, an employee or a key person of the Agency or an affiliate of the Agency, and does not have a relative who is, or has been within the last three years, a key person of the Agency or an affiliate of the Agency; (ii) has not received, and does not have a relative who has received, in any of the last three fiscal years, more than ten thousand dollars in direct compensation from the Agency or an affiliate of the Agency; (iii) is not a current employee of or does not have a substantial financial interest in, and does not have a relative who is a current officer of or has a

substantial financial interest in, any entity that has provided payments, property or services to, or received payments, property or services from, the Agency or an affiliate of the Agency if the amount paid by the Agency to the entity or received by the Agency from the entity for such property or services, in any of the last three fiscal years, exceeded the lesser of ten thousand dollars or two percent of such entity's consolidated gross revenues if the entity's consolidated gross revenue was less than five hundred thousand dollars; twenty-five thousand dollars if the entity's consolidated gross revenue was five hundred thousand dollars or more but less than ten million dollars; one hundred thousand dollars if the entity's consolidated gross revenue was ten million dollars or more; or (iv) is not and does not have a relative who is a current owner, whether wholly or partially, director, officer or employee of the Agency's outside auditor or who has worked on the Agency's audit at any time during the past three years.[1]

9. **"Indirect Financial Interest"**. A person has an "Indirect Financial Interest" in an entity if a Relative, as is defined herein, has an ownership interest in that entity or if the person has ownership in an entity that has ownership in a partnership or professional corporation.

10. **"Key Person"**. "Key Person" means any person who is in a position to exercise substantial influence over the affairs of the Agency, as determined in accordance with current laws, rules and regulations.

11. **"Officer"**. "Officer" means those individuals designated as officers in the by-laws of the Agency and those who are otherwise appointed as officers of the Agency in accordance with its by-laws.

12. **"Ordinary Course Of Business Transaction"**. An "Ordinary Course of Business Transaction" is one that is consistent either with the Agency's consistently applied past practices in similar transactions or with common practices in the industry in which the Agency operates.

13. **"Related Party"**. "Related Party" means member of the Covered Group of the Agency or any Affiliate of the Agency or any other person who exercises the powers of Directors, Officers or Key Persons over the affairs of the Agency or any Affiliate of the Agency; (ii) any Relative of any individual described in clause (i) of this definition; or (iii) any entity in which any individual described in clauses (i) or (ii) of this definition has a 35% or greater ownership or beneficial interest or, in the case of a partnership or professional corporation, a direct or indirect ownership interest in excess of 5%.

[1] "Compensation" does not include reimbursement for expenses reasonably incurred as a director or reasonable compensation for service as a director as permitted by paragraph (a) of section 202 (General and special powers) of this chapter; and "payment" does not include charitable contributions, dues or fees paid to the corporation for services which the corporation performs as part of its nonprofit purposes, or payments made by the corporation at fixed or non-negotiable rates or amounts for services received, provided that such services by and to the corporation are available to individual members of the public on the same terms, and such services received by the corporation are not available from another source.

14. **"Related Party Transaction"**. "Related Party Transaction" means any transaction, agreement or any other arrangement in which a Related Party has a financial interest and in which the Agency or any Affiliate of the Agency is a participant.

15. **"Relative"**. "Relative" means a Covered Group Member's (i) domestic partner, as defined in New York Public Health Law § 2994-a; [2] (ii) his or her ancestors, brothers and sisters (whether whole or half-blood), children (whether natural or adopted), grandchildren, great-grandchildren; or (iii) the spouse or domestic partner of his or her brothers, sisters, children, grandchildren, and great-grand-children.

[2] If you have any questions as to who is or is not a domestic partner under New York law, please consult with the compliance officer.

"Domestic partner" means a person who, with respect to another person:
(a) is formally a party in a domestic partnership or similar relationship with the other person, entered into pursuant to the laws of the United States or of any state, local or foreign jurisdiction, or registered as the domestic partner of the other person with any registry maintained by the employer of either party or any state, municipality, or foreign jurisdiction; or
(b) is formally recognized as a beneficiary or covered person under the other person's employment benefits or health insurance; or
(c) is dependent or mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners including but not limited to: common ownership or joint leasing of real or personal property; common householding, shared income or shared expenses; children in common; signs of intent to marry or become domestic partners under paragraph (a) or (b) of this subdivision; or the length of the personal relationship of the persons.

Each party to a domestic partnership shall be considered to be the domestic partner of the other party. "Domestic partner" shall not include a person who is related to the other person by blood in a manner that would bar marriage to the other person in New York state. "Domestic partner" also shall not include any person who is less than eighteen years of age or who is the adopted child of the other person or who is related by blood in a manner that would bar marriage in New York state to a person who is the lawful spouse of the other person.

# D10: Protocols for Investigations and Implementing Corrective Action, Including Discipline

## POLICY

To be effective and to combat fraud, waste and abuse in the course of operations, a compliance program must institute procedures for investigating compliance issues and implementing appropriate corrective action. Therefore, the Agency has established and implemented procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to prevent recurrence, and ensure ongoing compliance with federal health care programs requirements (e.g., Medicare and Medicaid). Below are the procedures that the Agency has adopted.

## PROCEDURE

### A. INVESTIGATION

A compliance problem may be uncovered as the result of a report to the Compliance Officer, an internal compliance assurance review, the review of a new regulation or governmental fraud alert, or from another source. Such problems might include any of the following: errors or inconsistencies in time or task entries; evidence that the Agency is billing for claims for services that were not performed or ordered; that the patient care documentation does not adequately support the billing codes selected; or suspect financial relationships with other providers who have a referral relationship with the Agency.

Upon receiving a report or otherwise learning of a possible compliance issue, the Compliance Officer will bring such report to the attention of the Compliance Committee**.** The Compliance Officer or his/her designee(s) will promptly conduct an investigation and take all necessary and appropriate actions. Such investigations may be undertaken under the supervision and direction of outside counsel, as necessary and appropriate. All Affected Individuals are expected to cooperate in any investigation.

In undertaking investigations, the Compliance Officer shall consult with the respective manager and/or member of the Compliance Committee who has responsibility for the unit. The Compliance Officer may utilize other Agency employees (consistent with appropriate confidentiality), outside attorneys, outside accountants and auditors or other consultants or experts for assistance or advice.

Depending on the nature of the potential compliance issue, an investigation may include interviews with Affected Individuals, documentation reviews and a root cause analysis. The objective of such an investigation will be to determine whether, first, a compliance issue exists or there has been a violation of the Compliance Program (including the Agency's compliance policies and procedures, the Code of Conduct or other applicable laws, regulations or

requirements). If an issue or violation does exist, then the investigation will attempt to determine its root cause so that appropriate and effective corrective action may be instituted.

If the matter concerns potentially improper or incorrect billing or related issues, the investigation may include, for example, the selection for review of a small, random sampling of claims "in the pipeline" (that is, claims for services that have been performed, documented and coded, but not yet submitted for payment) along with the related supporting documentation. If the review of these claims warrants, the sample will be expanded to additional claims "in the pipeline" so that the extent of any problem may be more accurately assessed. During these reviews, any claims that appear to be improper or inadequate will be held and not submitted for payment until all questions regarding them have been resolved. As appropriate, retrospective claims review may also be conducted. If it is determined at the conclusion of such an investigation that any claims were submitted in error to the government or any other payer, any payments received will be promptly refunded in accordance with applicable law, regulation and/or contractual requirement(s) (see the General Guidelines for Refunding Overpayments, below).

The Compliance Officer or his/her designee(s) will sufficiently document their investigative steps and the resolution/outcome.

The investigation of the compliance issue shall be documented and shall include any alleged violations, a description of the investigative process, copies of interview notes and other documents essential for demonstrating that the required provider completed a thorough investigation of the issue.

If credible evidence is identified or there is a credible belief that a State or Federal law, rule or regulation has been violated, it is required that such violation is promptly reported to the appropriate governmental entity. The Compliance Officer shall receive copies of any reports submitted to governmental entities.

## B. CORRECTIVE ACTION, DISCIPLINE AND REFUNDING OVERPAYMENTS

1. **Corrective Action – Generally.** Whenever a compliance issue is uncovered, regardless of the source, the Compliance Officer will ensure that prompt, thorough, appropriate and effective corrective action is implemented. In discharging this responsibility, the Compliance Officer may work in consultation with outside counsel and others, as appropriate to correct the problem. All Affected Individuals are expected to assist in the resolution of compliance issues.

   Any corrective action and response implemented must be designed to ensure that the violation or problem does not recur (or to reduce the likelihood that it will recur) and must be based on an analysis of the root cause of the issue. In addition, the corrective action plan should include, whenever applicable, a review of the effectiveness of the corrective action following its implementation. If such a review establishes that the corrective action plan has not been effective, then additional or new corrective actions must be implemented.

Corrective actions may include, but are not limited to, the following:

- Informing and discussing with the offending personnel both the violation and how it may be avoided in the future;
- Providing remedial education (formal or informal) to ensure that there is an understanding of the applicable laws, rules, regulations and/or requirements;
- Conducting a follow-up review to ensure that the problem is not recurring;
- Having personnel go through a cycle or cycles of remedial education and/or focused audits;
- Imposing discipline, as set forth below;
- Suspending claims submission, in whole or in part, of the services provided by a specific individual;
- Refunding any past payments that resulted from any improper claims, to the extent required or otherwise appropriate (see the General Guidelines for Refunding Overpayments, below);
- Self-disclosing to an appropriate governmental agency or other payer, to the extent required or otherwise appropriate (including, but not limited to the federal DHHS, OIG and the New York State DOH and OMIG);
- Modifying or improving the Agency's business practices; and/or
- Modifying or improving the Compliance Program to better ensure continuing compliance with applicable Federal and State laws, rules, regulations and/or contractual requirements.

If it appears that a larger, systemic problem may exist, then possible modification or improvement of the Agency's compliance, claims development and submission and/or other practices will be considered. Such action might include, in addition to that listed above, creating new procedures, or modifying existing procedures, so as to ensure that similar issues will not recur in the future. Possible changes or additions to procedures will be reviewed by the Compliance Officer and will be approved by the Compliance Committee.

The Compliance Officer will report to the CEO and the governing body regarding which corrective actions have been implemented and whether the compliance problem was corrected within a reasonable amount of time.

2. **Discipline.** All Agency Affected Individuals are expected to adhere to the Code of Conduct, the Compliance Program, and applicable Agency compliance policies and procedures. If the Compliance Officer concludes, after an appropriate investigation, that there has been a violation, appropriate discipline may be imposed. The Compliance Officer will be responsible for collaborating with the Agency's Administration and the Human Resource Manager regarding appropriate action. Discipline may include, but is not necessarily limited to oral warnings, written warnings, education, re-education,

suspension and/or termination from employment and/or affiliation with the Agency, suspension of an individual's billing and/or other appropriate action.

All personnel are subject to the same disciplinary action for committing similar offenses. The consequences of noncompliance will be consistently applied and enforced. The commitment to compliance applies to all personnel levels within the Agency organization.

Disciplinary action will be taken, and will be fairly and consistently enforced regardless of the offending Affected Individual's level or position as appropriate for actions including, but not limited to, the following:

- Failing to report suspected problems;
- Authorizing or participating in non-compliant behavior;
- Encouraging, directing, facilitating or permitting either actively or passively, non-compliant behavior;
- Refusing to cooperate in the investigation of a potential violation;
- Failure to assist in the resolution of compliance issues; and/or
- Intimidating or retaliating against an individual for good faith reporting of a compliance violation or other good faith participation in the Compliance Program.

The type of disciplinary action shall be imposed on an escalating basis and shall consider a variety of factors. Such factors may include, but are not necessarily limited to: (1) the nature of the violation; (2) the time period affected; (3) the amount involved; (4) whether the violation was committed intentionally, recklessly, negligently, or mistakenly; (5) whether the individual has committed any other violations in the past; (6) whether the individual self-reported his or her misconduct; and/or (7) whether (and the extent to which) the individual cooperated in connection with the investigation of the misconduct. Intentional or reckless behavior shall be subject to more significant sanctions. The disciplinary procedure shall conform with collective bargaining agreements, when applicable.

The foregoing is not intended, and shall not be viewed, as a limitation on the Agency's right or ability to impose more than one disciplinary sanction in a particular situation, to impose any other or additional disciplinary sanctions that may be appropriate and permissible in a particular situation, or to take any other actions, measures or sanctions that may be appropriate and permissible in a particular situation.

Any disciplinary action taken and the corrective action implemented shall be documented.

**3.** Guidelines for Refunding Overpayments.
It is the Agency's policy:

- To not retain any payments to which it is not entitled. To that end, reports or other information indicating that an overpayment may have been received must be immediately brought to the Compliance Officer's attention;
- To exercise reasonable diligence in timely investigating and quantifying any and all potential overpayments; and
- To promptly report, return and explain in writing to the appropriate government agency, contractor or payer (including but not limited to, the New York State Department of Health or the New York State OMIG), any identified overpayments in accordance with applicable legal, regulatory, contractual and/or other requirements or guidance.

Note that governmental and private insurance payers may have different rules concerning when and how identified overpayments must be handled.

For example, under the Federal Affordable Care Act statute (the "ACA"), Medicare and Medicaid overpayments must be reported, returned and explained in writing within 60 days of the date the overpayment is identified. For Medicare Part A and Part B purposes, an overpayment is considered to have been "identified" when a person has or should have, through the exercise of "reasonable diligence," determined that an overpayment has been received and has quantified the amount of the overpayment. "Reasonable diligence" includes both proactive compliance activities conducted in good faith to monitor the receipt of overpayments, as well as investigations conducted in good faith and in a "timely manner" in response to obtaining "credible information" about a potential overpayment. Medicare considers a "timely manner" to be at most six (6) months from receipt of credible information, except in extraordinary circumstances. co Once an overpayment has been "identified," the person must report, return and explain in writing the overpayment within 60 days.

With regard to Medicaid, the Agency will exercise reasonable diligence to determine whether it has received any overpayments and, if so, to quantify the amount of the overpayment. The Agency will, as appropriate, report, return and explain in writing any identified Medicaid overpayments within 60 days of identifying the overpayment, to the New York State Office of the Medicaid Inspector General ("OMIG"), through its self-disclosure program. The requirements of OMIG's self-disclosure program and related information may be found at: https://www.omig.ny.gov/provider-resources/self-disclosure.

Any questions regarding when and how potential overpayments are to be addressed by the Agency must be immediately brought to the attention of the Compliance Officer, who may consult with outside counsel, as necessary and appropriate.

## C. RECORDKEEPING

The Compliance Officer will maintain a record of all investigations, corrective actions and disciplinary actions imposed pursuant to this Policy. Such records shall be maintained for no fewer than ten (10) years from the later of the conclusion of the investigation or the imposition of the corrective action or disciplinary action(s), or for such longer period of time as may be required by applicable law, regulation or contract.

## D. PERIODIC REVIEW OF THIS POLICY

The Agency will periodically review this Policy and Procedure (no less than annually) to ensure that it is modified as necessary in order to remain current with applicable law, regulation and guidance, as well as our contractual requirements.

# D11: Responding to Government Inquiries

## POLICY

It is the Agency's policy to comply with the law and cooperate with legitimate governmental investigations or inquiries.

## DEFINITIONS

**A.** Civil Investigative Demand. A "civil investigative demand" (CID) is a tool used to obtain documents and information relevant to a False Claims Act investigation. A CID may be issued by the U.S. Department of Justice (DOJ), e.g, U.S. Attorneys.

**B.** Failure to Grant Immediate Access. "Failure to grant immediate access" means—

1. The failure to produce or make available for inspection and copying the requested material upon "reasonable request" (as defined below), or to provide a compelling reason why they cannot be produced, within 24 hours of such request to the U.S. Department of Health and Human Services' (DHHS) Office of Inspector General (OIG) or a State Medicaid Fraud Control Unit (MFCU).
2. When the OIG or MFCU has reason to believe that the requested material is about to be altered or destroyed, the failure to provide access to the requested material at the time the request is made.

**C.** Law Enforcement Officer. For purposes of this policy and procedures, "law enforcement officer" refers to any officer or investigator from the U.S. DOJ, or a designee (e.g., a U.S. Attorney), the OIG, MFCU, or Office of Medicaid Inspector General (OMIG).

**D.** Reasonable Notice. Under New York law, "reasonable notice" means a written request made by a properly identified agent of the NY State Department of Health (DOH), OMIG or the MFCU made either during hours that the Agency is open for business or mailed to the Agency at the address on file with the Agency. The request must include a statement of the authority for the request, the definition of "reasonable notice," and advise the Agency of the penalties for failure to comply.

**E.** Reasonable Request. Under federal regulations, "reasonable request" means a written request made by a properly identified agent of the U.S. DHHS (including the OIG), of a State survey agency or of the MFCU during hours that the facility, agency or institution is open for business. The request must include a statement of the authority for the request, the rights of the entity in responding to the request, the definition of reasonable request and immediate access, and the penalties for failure to comply.

**F.** Regulators. For purposes of this policy and procedure, "regulators" refers to agents of the NY State DOH.

**G.** Section 504.3 Request. Section 504.3 of Title 18 of the N.Y. Codes, Rules and Regulations requires Medicaid providers to prepare and maintain contemporaneous records demonstrating their right to receive payment under the Medicaid program and to furnish such records upon request. A "Section 504.3 request" for records may be issued by: (i) the NY State Department of Social Services; (ii) the U.S. DHHS Secretary; (iii) the NY State MFCU; and (iv) the NY State DOH, including the OMIG.

**H.** Subpoena. "Subpoenas" require the production of documents or testimony. A subpoena may be issued by, among other government agencies, : (i) the U.S. Department of Justice (e.g., the U.S. Attorney's Office; FBI, DEA); (ii) the OIG; (iii) the MFCU; and (iv) the OMIG. Subpoenas from other law enforcement agencies may or may not require a judge's order.

## PROCEDURES

**A.** On-Site Regulators. Regulators from DOH, may come to the Agency to conduct on-site surveys or inquiries. All regulators entering the Agency should be directed to the Compliance Officer and in his or her absence, the Executive Director. Affected Individuals should not turn over any Agency records without prior approval from the Compliance Officer or the Executive Director.

**B.** Accommodating Law Enforcement Officers. Upon receipt of a "reasonable request" (as defined above), law enforcement officers from the OIG, or upon "reasonable notice" (as defined above), law enforcement officers from the New York MFCU, DOH, or OMIG are to be granted timely access to the Agency's facilities and its records for the purpose of conducting audits, investigations, reviews, or other statutory functions. All law enforcement officers entering the Agency's facilities must be directed to the Compliance Officer and in his or her absence, the Executive Director who shall request the name, title, business identification and badge # (if applicable) of each officer. Affected Individuals should not turn over any Agency records without prior approval from the Compliance Officer or the Executive Director.

**C.** Accommodating Requests for Interviews. The Agency encourages Affected Individuals to fully cooperate with law enforcement officers and investigations.

**1.** Personnel Interviews. Affected Individuals may speak voluntarily with law enforcement officers, and the Agency will not attempt to obstruct any government inquiry or prevent any Affected Individuals from speaking with such officers. However, Affected Individuals should be aware that they are permitted to refuse to speak with any officer and have the right to request that a representative of the Agency or legal counsel be present before they speak with an officer. If a law enforcement officer goes to any Affected Individual's home, the individual has the right to refuse to speak with the officer and to have an Agency representative or counsel present. Affected Individuals may also request that the interview take place at the Agency.

- Before speaking with law enforcement officers, it is recommended that the Affected Individuals ask for the officer's name and telephone number and identification, and then contact his or her supervisor and the Compliance Officer who should then contact legal counsel.
- Affected Individuals are also reminded that, while they may speak with government agents in their personal capacity, they may not present themselves as an official representative of the Agency without first obtaining authorization from the Agency.

**2.** Law Enforcement Officers with a Subpoena, Civil Investigative Demand or Section 504.3 Notice. If investigators from a law enforcement agency appear at the Agency with a subpoena, a CID or a Section 504.3 request for specific records, the following should occur:

- Immediately Contact the Compliance Officer. Once the individual being served with the Subpoena, CID or a Section 504.3 request has obtained proper identification from the law enforcement officer or investigator, he or she should contact the Compliance Officer immediately his or her absence, the Executive Director. No records or information should be given to any law enforcement officer or investigator without prior approval of the Compliance Officer or the Executive Director who may first consult with outside counsel, as necessary and appropriate. Generally, a subpoena, CID or a Section 504.3 request must give the Agency adequate time to reply; thus, a law enforcement officer should not arrive at the Agency expecting an immediate response to such documents.
- Contact Legal Counsel. The Compliance Officer or Executive Director should contact legal counsel upon receiving a subpoena, CID or a Section 504.3 request. Although the Agency intends to fully cooperate with all lawful investigations, some of the requested material may be privileged and should be reviewed by attorneys prior to disclosure.
- Accurate Response. Any response to a subpoena, CID or a Section 504.3 request must be accurate and complete.

**3.** Law Enforcement Officers with a Search Warrant. A valid search warrant enables law enforcement officers to enter a premise, search for evidence of criminal activity, and seize that evidence for use in a criminal prosecution. Law enforcement officers with a search warrant, however, do not have unlimited authority. The Agency aims to minimize disruption should law enforcement officers execute a search warrant. If a law enforcement officer presents a search warrant at the Agency, Affected Individuals should do the following:

- Advise the Compliance Officer or the Executive Director of the Agency of the Search. The individual should immediately tell the Compliance Officer or the Executive Director about the search warrant and the presence of the investigators.

- Contact Legal Counsel Immediately. Any Affected Individual served with a warrant should request the opportunity to call legal counsel. If this request is refused, the individual, in a respectful manner, should indicate that the refusal violates the Agency's rights and should document the refusal in detail.
- Request a Copy of the Search Warrant and Accompanying Affidavit. A search warrant contains limits as to what areas may be searched and what property may be seized. Affected Individuals should be aware of these limits and ensure that the officers confine their search to its proper boundaries.
- Do Not Consent to the Search. Although it is important to be cooperative with the investigators, it is equally important to tell them that the Agency objects to the search and is complying under compulsion of law.
- Protect Personnel. Investigators will normally use the execution of a search warrant as an opportunity to question the Affected Individual. The search warrant, however, does not give the investigators authority to require Affected Individuals to answer questions. Affected Individuals should be cooperative and respectful but may refuse to answer questions without an attorney present. Affected Individuals may be sent home or to another section of the office during the execution of a search warrant. Some persons will be selected to remain with counsel and monitor the search.
- Keep Records Regarding the Search. The search should be carefully monitored and recorded. Records should include the names and backgrounds of the investigators, times, dates and scope of the search, areas searched, and a detailed list of items seized. Affected Individuals should request permission to video the search; if such request is refused, the refusal should be documented. Investigators should never be left alone in any area of the Agency during a search.
- Be Cooperative. Affected Individuals should be cooperative and not do anything that will impede, obstruct or antagonize the investigators during their search. Such impediments could be considered obstruction of justice and lead to a person's arrest.

## NO DESTRUCTION OR ALTERATION OF RECORDS OR EVIDENCE

Affected Individuals may never destroy, alter or change in any way any of the Agency's records in response to a request from the government for such records. Even additions to records intended, in good faith, to add appropriate entries to "complete" the records are absolutely prohibited once a subpoena or government request for a document has been received. Any such action will subject the Affected Individuals involved to immediate discharge from employment or affiliation with the Agency and possible criminal prosecution.

# D12: Waiving/Reducing Coinsurance and Deductible Amounts

## POLICY

The Agency strives to provide the highest quality services to all of its patients, consistent with ethical standards, and in accordance with all applicable laws. From time-to-time, the Agency may consider waiving, in whole or in part, our patients' coinsurance or deductible obligations in connection with the services we provide. However, there are certain legal considerations that govern when it may be appropriate to do so. Accordingly, all waivers/reductions of coinsurance or deductible obligations will be offered/given only in accordance with this Policy.

There are a variety of laws that govern the Agency's interactions with Federal health care program beneficiaries.[1] Contractual obligations to private insurers, as well as other laws, may also affect the Agency's ability to waive or reduce coinsurance or deductible obligations of privately insured patients. In order to comply with those laws and contractual obligations, it is the Agency's policy that waivers/reductions of coinsurance or deductible amounts may be offered to patients only when all of the following conditions are met:

- **No Advertising/Soliciting**. The waiver or reduction is not offered as part of any advertisement or solicitation by the Agency or any of its Personnel; and
- **May Not Be Routinely Offered**. The waiver or reduction is not routinely offered (that is, waivers/reductions may not be the Agency's general business practice and may only be offered occasionally); and
- **Good Faith Determination of Financial Need or Reasonable Collection Efforts Required**. The Agency waives or reduces the coinsurance or deductible **only** after (a) we have made a good faith and documented determination that the individual is indigent or in financial need; **or** (b) we fail to collect the coinsurance or deductible amounts after making reasonable collection efforts (that is, after such efforts, the Agency exercises its business judgment not to pursue the full legal remedies available to it to collect the amount(s) it is owed).

## PROCEDURE

**A.** If a patient requests that a co-insurance or deductible amount be waived, the patient must complete the Agency's Financial Aid Request Form (attached to this Policy as Appendix A), explain the nature and extent of the financial hardship, and provide the Agency with

[1] For purposes of this Policy, "Federal health care program" means any plan or program that provides health benefits, whether directly through insurance or otherwise, which is funded directly, in whole or in part by the United States Government and includes certain State health care programs. Examples include, but are not limited to: Medicare, Medicaid, Veterans' programs and the State Children's Health Insurance Programs. The Federal Employees Health Benefits Program is not included in this definition.

written documentation of his or her financial need. The Agency will maintain such documentation of patient financial need in an easily accessible central location.

**B.** If appropriate documentation is not obtained, the patient must be billed pursuant to the Agency's normal procedures. Coinsurance or deductible amounts will then be written off only if our normal procedures have failed to result in collection of those amounts.

**C.** All requests for waivers of coinsurance and deductible amounts will be determined on an individual basis and must be pre-approved by the Compliance Officer, or his or her designee.

## FAILURE TO FOLLOW THIS POLICY AND PROCEDURE

A failure to follow this Policy and Procedure may result in disciplinary action in accordance with the terms of our Compliance Program.

***Any questions concerning compliance with this Policy must be directed to the Agency's Compliance Officer.***

# APPENDIX A

## Financial Need Form

**Patient Information**

Patient Name: _____

Address: _____

City/State/Zip: _____

**Responsible Party** ***(if different than patient)***

Name: _____

Address:_____

City/State/Zip: _____

**Do you currently have insurance coverage?** _____ If yes, please indicate the type:

- ☐ Medicare
- ☐ Medicaid
- ☐ Commercial _____

**Please indicate your current employment status:**

- ☐ Full-time employed
- ☐ Part-time employed
- ☐ Not currently employed

Occupation _____
Employer business name: _____
Employer address: _____
Employer phone number: _____

**Please list your Adjusted Gross Income**: $_____

- Your Income $_____
- Spouse's Income $_____
- Other Household Income $_____

Please give a brief description of your current financial situation, including monthly expenses and any special circumstances which you would like the Agency to consider as you are evaluated for financial assistance:

_____

_____

_____

_____

I certify/attest that the information provided above is, to the best of my knowledge, true and accurate. If requested by the Agency, I will provide the necessary documentation to support the information provided on this form. I further understand that any waiver/reduction determination made by the Agency applies only to the amount indicated below, and only for the services and care provided to me on the date specified below. Any future medical expenses are not included in this determination and will be made on a case-by-case basis.

Signature: _____ Date:_____

Reviewed by: _____ Date: _____

Approved:

- ☐ Yes
  - ☐ Coinsurance amount of $ _____ for the services provided on _____.
  - ☐ Deductible amount of $ _____ for the services provided on _____.
  - ☐ Fee/partial fee for self-pay patients, or patients with insurance that does not cover the services provided on _____ to $_____.
- ☐ No

# D13: Contractor Agreement Requirements Policy

## POLICY

It is the policy of the Agency to require contracts with its Contractors[1] to specify that they are subject to the Agency's compliance program. The extent to which a Contractor is subject to the Agency's Compliance Program is dependent on the scope of the contracted authority and affected risk area. The Agency's contracts with Contractors shall include termination provisions, which provide that failure to adhere to the Agency's compliance program requirements shall result in termination of such contracts.

**1.** Protocol. The Agency shall review its contracts with contractors, subcontractors, vendors and independent contractors to determine: (i) if that party meets the definition of a Contractor; and (ii) shall identify the Agency's risk area affected by the Contractor and related contract. The Agency shall create and maintain a list identifying Contractors, the date and term of the contract (including the termination date), indicate the services being provided, and the Agency's risk area affected. This list shall be reviewed and updated by the Compliance Officer or his/her designee and included as an item in the Agency's Compliance Work Plan. If it is unclear whether a party meets the definition of a Contractor, counsel must be consulted to make a determination.

**a.** New Contracts and Renewals of Contracts on or After March 28, 2023. Effective March 28, 2023, all new contracts and renewals of existing contracts with Contractors must specify the requirement to adhere to the Agency's compliance program within the scope of the contracted authority and affected risk areas, and that failure to adhere to the Agency's compliance program requirements shall result in termination of such contract.

**b.** Existing Contracts That Remain in Effect Beyond March 28, 2025. If the Agency identifies contracts with Contractors that were in effect before March 28, 2023, but do not terminate until after March 28, 2025, the Agency shall make efforts to obtain the Contractor's consent to amend the agreement without any concessions from the Agency. If the Contractor refuses such a request, the Agency shall document its efforts and should consult with counsel to assess its available options, including notifying the Bureau of Compliance at the Office of the Medicaid Inspector General ("OMIG") at compliance@omig.ny.gov.

[1] As set forth in the Compliance Manual:

**"Contractors"** means contractors, agents, subcontractors, and/or independent contractors who are affected by the Agency's risk areas.

**"Risk areas"** are those areas to which the Agency's Compliance Program applies. This includes those areas of operation affected by the Compliance Program and applies to: (i) billings; (ii) payments; (iii) ordered services; (iv) medical necessity; (v) quality of care; (vi) governance; (vii) mandatory reporting; (viii) credentialing; (ix) contractor, subcontractor, agent or independent contract oversight; and (x) other risk areas that are or should reasonably be identified through our organizational experience.

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