

CAREGIVER POLICY AND PROCEDURES

Both RESIDENT and All Caregivers (Full and Part-Time) must complete and sign this 2-page CAREGIVER'S REGISTRATION APPLICATION and receive a copy.

WRITTEN AUTHORIZATION IS REQUIRED

- LIVE-IN/FULL-TIME CAREGIVERS - can only provide such care, based on a written request from the Resident's physician. All FULL-TIME CAREGIVERS MUST ATTEND AN ORIENTATION.
- PART-TIME CAREGIVERS – no physician's request is required/nor is Orientation Meeting required.

NHSB COMMUNITY AMENITIES

- ENTRY KEY CARDS – will not be issued to Caregivers.
- Caregivers DO NOT have personal use of the recreation facilities and amenities.
- Caregivers and Relief Caregivers are not permitted to bring children to work.

RULES REGARDING CAREGIVERS

1. The RESIDENT must notify the Administration Office when engaging Caregivers.
2. Residents must inform the Office of any changes in Caregivers, or multiple Caregivers, (e.g., day shift/night shift caregivers)
3. CAREGIVER I.D. BADGES are required to be worn by ALL CAREGIVERS in the common areas. A **Deposit Fee** is required to obtain **New Horizons I.D. Badge**. This is refunded when the badge is returned to the office within 30 days of departure.
4. FULL-TIME CAREGIVERS - must always be with the patient when in the Common Area. Running Resident Errands is the exception.
5. The NHSB Vehicle Permit Sticker is required for Caregiver parking. Obtain it from the office at **no cost**.
6. SAFETY & EMERGENCY: All Caregivers must know the following.
 - a. The location of the building's FIRE EXTINGUISHER
 - b. The location of the condominium unit WATER TURN-OFF
 - c. Wipes must be DISPOSED OF in the trash. NEVER DISPOSE WIPES (of any kind) down the drain or toilet as it CLOGS the plumbing.

Resident Signature: _____

Date: _____

Caregiver Signature: _____

Date: _____

**Orientation Interview
Signature:** _____

Date: _____

**Orientation Manager's
Signature** _____

Date: _____

NEW HORIZONS SOUTH BAY ASSOCIATION

CAREGIVER'S REGISTRATION APPLICATION

Unit #	Bldg. #	Start Date:
_____	_____	_____
Resident's Name	_____	
_____	_____	
Resident's Address	Phone #	_____
_____	_____	_____
Physician Request for Full Time Caregiver (Attached)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____

PRIMARY CAREGIVER'S INFORMATION

Name	DOB
_____	_____
Address	Just Day Care <input type="checkbox"/>
_____	_____
Work Hours	Start Date
_____	_____

Emergency Contact for Primary Caregiver

Name	Relationship
_____	_____
Address	Phone
_____	_____

SECONDARY CAREGIVER'S INFORMATION

Name	DOB
_____	_____
Address	Just Day Care <input type="checkbox"/>
_____	_____
Work Hours	Start Date
_____	_____

Emergency Contact for Primary Caregiver

Name	Relationship
_____	_____
Address	Phone
_____	_____