



## IMPERIAL CAREGIVER, 1200 Morris Turnpike Ste 3005, Short Hills, NJ 07078

### CORPORATE COMPLIANCE POLICY FOR HOME HEALTH AGENCIES

#### A. INTRODUCTION

##### 1. Adoption

The following is hereby adopted as the compliance policy for Imperial Caregivers LLC, DBA Imperial Caregivers (hereinafter referred to as "the Home Health Agency").

##### 2. Purpose

The purpose of this policy is to enable the Home Health Agency to demonstrate integrity and honesty as a participant in federally and state funded health care programs and its compliance with applicable laws and regulations.

The Home Health Agency will implement and maintain the requirements specified herein to the extent reasonably possible. The Home Health Agency and

- (a) each of its corporate trustees, directors, officers, and employees;
- (b) any individuals engaged directly by the Home Health Agency to provide patient care services, such as nurses, physical therapists, occupational therapists, speech therapists, medical social workers and other health care professionals;
- (c) individuals involved in the management, sale, marketing, and billing of Home Health Agency services (whether employees or independent contractors); and
- (d) all individuals who order home health services shall maintain the business integrity and honesty required of a participant-supplier in federally funded health care programs.

##### 3. Annual Review

The compliance policy will be reviewed at least annually and updated as necessary by the Compliance Officer and approved by the Compliance Committee.

All new employees will be asked to sign a statement certifying that they have received, read and understood the standards of conduct outlined in this policy. Such statements shall also be signed by all employees when policies or standards of conduct are amended or new ones are adopted. Certifications shall be maintained by the Compliance Officer.

#### B. STANDARDS OF CONDUCT

It is the policy of the Home Health Agency to use its best efforts to avoid fraud, waste and abuse and to adhere to all guidelines and regulations governing federally and state funded health care programs. Policies outlining standards of conduct shall be distributed to all individuals who are affected by the specific policy at issue, along with new and amended or revised compliance policies when available.

##### 1. Claim Development and Submission Process

- (a) Submission of claims for payment to Medicare, Medicaid and other federal health programs will be in accordance with current reimbursement rules, policies and procedures promulgated by the Health Care Financing Administration, the state Medicaid agency, any applicable fiscal intermediary or carrier or other agency with responsibility for the program in question.
- (b) Claims for payment shall be submitted to Medicare, Medicaid or other federally funded health care programs only for medically necessary services for homebound patients that were actually rendered by qualified, licensed personnel. Only one bill shall be submitted for each service provided.
- (c) Claims will be submitted only when appropriate documentation supports the claims and only when such documentation is maintained for audit and review. Such documentation shall include at least a properly certified plan of care dated no more than 60 days before the date of service, nursing and/or progress notes and visit slips or logs. Documentation shall include the length of time spent with patients and the identity and professional licensure or certification of the individual providing the service. The documentation used as the basis for claims submission shall be organized in a legible form to enable audit and review.
- (d) All professional services rendered to patients shall be documented in a proper and timely manner so that only accurate and properly documented services are billed. Clinical and reimbursement staff shall use their best efforts to communicate effectively and accurately with each other to assure compliance.
- (e) Compensation for billing department personnel (including coders) and billing consultants shall not contain any financial incentive to submit improper claims or codes.
- (f) Diagnosis and procedure codes for home health services reported on the claim shall be based on the patient's medical record and other documentation, and shall comply with all applicable official coding rules and guidelines. The documentation necessary for accurate code

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assignment shall be available to the coding staff. The Health Care Financing Administration Common Procedure Coding System (HCPCS), International Classification of Disease (ICD), Home Health Agency's Current Procedural Terminology (CPT), or revenue codes (or successor codes) used by the billing staff shall accurately describe the service that was ordered by the physician and performed by the Home Health Agency.

- (g) Previously submitted claims shall be randomly examined for accuracy and compliance with applicable rules and regulations and the Compliance Officer shall inform the fiscal intermediary or carrier of any steps taken to monitor the Home Health Agency's claim submission process.
- (h) The fiscal intermediary or carrier shall be promptly advised of any incorrectly submitted claim and shall be promptly reimbursed for any overpayment. Where possible, the beneficiary shall be reimbursed for any copayment or deductible incorrectly paid.

**2. Medical Necessity**

- (a) Claims shall be submitted to federally and state funded health care programs only for services that are medically necessary and that meet the requirements of a qualifying service. Upon request, the Home Health Agency shall provide documentation, such as physician orders, a properly certified plan of care and other patient records, that support the medical necessity of a service that the Home Health Agency has provided and billed to a federal or state program.
- (b) A clear, comprehensive summary of the "medical necessity" definitions and applicable rules of the various government and private plans shall be prepared by the Compliance Officer and disseminated and explained to appropriate Home Health Agency personnel, including physicians who order home health services.
- (c) At least annually, the Compliance Officer and Medical Director shall review the frequency and duration of services being performed by the Home Health Agency to determine whether patients' medical conditions justify the number of visits provided and billed.
- (d) At least annually, the Home Health Agency shall verify, through a random survey or otherwise, that beneficiaries have actually received the appropriate level and number of services billed.

**3. Homebound Beneficiaries**

The Home Health Agency shall use its best efforts to ensure that the homebound status of a Medicare beneficiary is verified and the specific factors qualifying the patient as homebound are properly documented. The following specific steps shall be taken to verify patients' homebound status:

- (a) The ordering physician shall certify that the beneficiary was confined to the home at the time the services were provided.
- (b) Written prompts on nursing note forms shall direct clinicians (e.g., registered nurse, licensed practical nurse) to adequately assess and document the homebound status and home health needs of Medicare beneficiaries, which may be used by the ordering physician in developing and authorizing a plan of care.
- (c) A written notice shall be sent to all Medicare beneficiaries reminding them that they must satisfy the regulatory requirements for homebound status to be eligible for Medicare coverage.

**4. Physician Certification of the Plan of Care**

The Home Health Agency shall take all reasonable steps to ensure that claims for home health services are ordered and authorized by a physician, including the following:

- (a) A plan of care shall be established, dated, and signed by a qualified physician before services are provided or billed.
- (b) The plan of care shall be reviewed by the ordering physician at least every 60 days in order for the beneficiary to continue to qualify for Medicare coverage of home health benefits.
- (c) Home health services shall be billed only if the physician has signed a certification attesting that the patient is confined to the home, is in need of skilled nursing care, or physical, speech or occupational therapy, is under the care of the physician and that a plan of care has been established and is periodically reviewed.
- (d) The Home Health Agency shall assist physicians who order home health services in determining the medical necessity of those services and in formulating appropriate and certified plans of care by properly documenting any assessment it has made of a beneficiary's home health needs.
- (e) The Home Health Agency shall remind or educate physicians, as appropriate, about the scope of their duty to certify patients for home health services to be reimbursed by Medicare.

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### **5. Cost Reports**

Submission of cost reports to Medicare, Medicaid and other federal health programs will be in accordance with current reimbursement rules, policies and procedures promulgated by the Health Care Financing Administration, the state Medicaid agency, any applicable fiscal intermediary or carrier, or other agency with responsibility for the program in question. All cost reports submitted to Medicare or Medicaid shall comply with the following rules:

- (a) all costs claimed shall be properly documented and classified;
- (b) allocations of costs to various cost centers are accurate and supported by verifiable and auditable data;
- (c) accounts containing both allowable and unallowable costs are analyzed to determine that unallowable costs are not claimed for reimbursement;
- (d) Medicare fiscal intermediary prior year audit adjustments are implemented and are either not claimed for reimbursement or, if claimed for reimbursement, are clearly identified as protested amounts on the subsequent cost report;
- (e) all related parties are identified on the cost report and all related party charges are reduced to the cost to the related party;
- (f) management fees are reasonable and necessary, and shall not include unallowable costs;
- (g) any return of overpayments shall be appropriately reflected in cost reports; and
- (h) in the event that an error is discovered after the submission of a cost report, the Medicare fiscal intermediary or other applicable payor shall be notified within 30 days.

### **6. Services Provided to Patients Who Reside in Assisted Living Facilities**

The Home Health Agency will provide services to patients who reside in assisted living facilities only to the extent that they are appropriate and not duplicative of those services provided or required to be provided by the facility. Upon a request for services for a patient residing in an assisted living facility, the following steps shall be followed:

- (a) the appropriate state licensing authority shall be contacted to determine any applicable state licensure and service requirements for the specific facility involved;
- (b) reasonable attempts will be made to verify the specific license, if any, held by the facility; and
- (c) the service agreement between the facility and the resident will be reviewed during the initial assessment visit to determine the extent and type of the services that the facility is contractually obligated to provide to the resident.

### **7. Relationships with Referral Sources**

- (a) Any contract or other financial arrangement with a physician or other health care provider who is in a position to refer patients to the Home Health Agency shall be in writing, shall conform to the Home Health Agency's Standards of Conduct Relating to Physician Contracts and shall be reviewed by legal counsel prior to execution.
- (b) No gifts, free services, or other incentives shall be offered to patients, relatives of patients, physicians, hospitals, contractors, assisted living facilities, or other individuals or entities who would be in a position to refer patients to the Home Health Agency.

### **8. Retention of Records**

The Home Health Agency shall follow the general rules and time periods outlined in the Home Health Agency's Document Retention Policy.

### **9. Business Ethics**

- (a) No employee, Board member or physician may make improper use of the Home Health Agency property or permit others to do so. Examples of improper use include the unauthorized appropriation or personal use of services, equipment, technology and patents, software, and computer and copying equipment and the alteration, destruction or disclosure of data. The occasional use of telephones, copying machines and office supplies, when the cost is insignificant, is permitted.
- (b) Seeking, accepting, offering or making any payment, gift or other thing of value to or from any subcontractor, vendor, supplier or potential contractor for the purpose of obtaining or acknowledging favorable treatment under a private or government contract or subcontract is strictly forbidden. Ordinary business courtesies or *de minimis* gifts (under \$100 in value) which are not solicited may be accepted.
- (c) All entries on books and records, including financial records, clinical records, and expense accounts, shall be accurate and complete and conform with applicable policies.
- (d) Employees shall use their best efforts to avoid violations of federal copyright laws, including, but not limited to laws, pertaining to, computer software.
- (e) Required time records shall be completed in a timely and accurate manner. No cost should be allocated which is unallowable, misallocated, contrary to a contract provision, or otherwise improper.

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- (f) All Board members, managers and employees shall refrain from any conduct during the performance of their duties that has the appearance of impropriety or that could reasonably be construed as contrary to the interests and mission of this organization *or the Ethical and Religious Directives for Catholic Health Facilities, as amended.*

### 10. Gifts from Vendors

Gifts from companies in the pharmaceutical, device, and medical equipment industries often serve an important and socially beneficial function. For example, drug companies have long provided funds for educational seminars and conferences. However, some gifts that reflect customary practices may not be consistent with the principles of medical ethics. To avoid the acceptance of inappropriate gifts, all employees of the Home Health Agency shall observe the following standards of conduct:

- (a) Gifts should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments may not be accepted.
- (b) Individual gifts of minimal value are permissible as long as the gifts are related to the individual's work (e.g., pens and notepads).
- (c) Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy by a company's sales representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor, who, in turn, can use the money to reduce the conference registration fee. Payments to defray the costs of a conference may not be accepted directly from the company by individuals who are attending the conference.
- (d) Subsidies from vendors may not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses, nor may subsidies be accepted to compensate for the individual's time. Subsidies for hospitality may not be accepted outside of modest meals or social events that are held as part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of individuals for their time or their travel, lodging, and other out-of-pocket expenses.
- (e) No gifts may be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures.

### C. DESIGNATION OF A COMPLIANCE OFFICER

The Chief Executive Officer shall designate a Compliance Officer. This individual shall report to the Chief Executive Officer and shall have access to other senior management, legal counsel and the governing body. The responsibilities of the Compliance Officer shall include:

1. overseeing and monitoring the implementation of the compliance program and reporting on a regular basis to the Chief Executive Officer and the Compliance Committee on the progress of implementation;
2. assisting in establishing methods to improve the Home Health Agency's efficiency and quality of services and to reduce the Home Health Agency's vulnerability to fraud, abuse and waste;
3. periodically revising the compliance program to conform to changes in the organization, the law, and policies and procedures of government and private payor health plans;
4. reviewing employees' certifications that they have received, read and understood the standards of conduct;
5. developing written compliance policies and procedures that are readily understandable by all employees;
6. coordinating and participating in a multifaceted education and training program that focuses on the elements of the compliance program and seeks to ensure that all appropriate employees and management know, and comply with, pertinent federal, state and private payor standards;
7. ensuring that independent contractors and agents who furnish nursing or other health care services to the clients of the Home Health Agency, or who provide billing services to the Home Health Agency, are informed of the Home Health Agency's standards of conduct with respect to coding, billing, and marketing, among other things;
8. coordinating personnel issues with the Home Health Agency's Human Resources/Personnel Office to ensure that the National Practitioner Data Bank and Cumulative Sanction Report have been checked with respect to all employees, medical staff, and independent contractors who order or provide services to home health patients;
9. assisting financial management in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments;

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10. independently investigating and acting on matters related to compliance, including the design and coordination of internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action and reporting thereon to the Corporate Compliance Committee and the Chief Executive Officer;
  11. developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation; and
  12. continuing the momentum of the compliance program and the accomplishment of its objectives long after the initial years of implementation.
- The Compliance Officer shall have the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient records, billing records, and records concerning the marketing efforts of the facility and the Home Health Agency's arrangements with other parties, including employees, professionals on staff, relevant independent contractors, suppliers, agents, supplemental staffing entities, and physicians. The Compliance Officer shall have the authority to consult with legal counsel when necessary.

**D. COMPLIANCE COMMITTEE**

The Compliance Committee shall be appointed by the Chief Executive Officer and shall consist of the Compliance Officer, who shall serve as its Chairperson, the Medical Director and such other individuals appointed by the Chief Executive Officer. The Committee's functions shall include:

1. analyzing the regulatory environment, the legal requirements with which the Home Health Agency must comply and specific risk areas;
2. assessing existing policies and procedures that address these areas for possible incorporation in the compliance program;
3. developing standards of conduct and policies and procedures to promote compliance;
4. recommending and monitoring the development of internal systems and controls to implement the Home Health Agency's standards, policies and procedures as part of its daily operations;
5. determining the appropriate strategy/approach to promote compliance and detect potential violations;
6. developing a system to solicit, evaluate and respond to complaints and problems; and
7. monitoring internal and external audits and investigations for the purpose of identifying troublesome issues and deficient areas experienced by the Home Health Agency and implementing corrective and preventive action.

**E. EDUCATION AND TRAINING**

1. Education and training are critical elements of the Corporate Compliance Program. All employees shall be required to attend at least one hour of training regarding corporate compliance each year. Employees shall receive such training when they are first hired and on a periodic basis thereafter. Attendance at such training sessions is a condition of continued employment and adherence to the provisions of the compliance program, including training requirements, shall be a factor in the annual evaluation of each employee. Any formal training undertaken as part of the compliance program shall be documented by the Compliance Officer.
2. Such training shall emphasize the Home Health Agency's commitment to compliance with federal and state statutes, regulations, program requirements, the policies of private payors and corporate ethics. It shall highlight the elements of the compliance program, including how to report suspected violations, summarize the fraud and abuse laws, and review coding requirements, claim development, the claim submission process and marketing practices that reflect current legal and program standards.

Basic Training: Basic training for appropriate corporate officers, managers and other employees shall include at least the following topics:

- (a) government and private payor reimbursement principles;
- (b) general prohibitions on paying or receiving remuneration to induce referrals;
- (c) improper alterations to clinical records;
- (d) the need for proper physician authorization and certification;
- (e) the need for accurate and timely documentation of services rendered, including the correct application of official ICD and CPT coding rules and guidelines;
- (f) patient rights and patient education;
- (g) compliance with Medicare conditions of participation; and
- (h) the duty to report misconduct and how to do so.

Targeted Training: Targeted training shall be provided to corporate officers, managers and other employees whose actions affect the accuracy of the claims submitted to government and private payors, such as employees involved in the coding, billing, cost reporting and marketing processes.

Supervisors and managers involved in the claims and cost report development and submission processes shall inform all supervised employees and relevant contractors of the following:

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- (a) the compliance policies and legal requirements pertinent to their function;
- (b) that strict compliance with these policies and requirements is a condition of employment; and
- (c) the Home Health Agency will take disciplinary action up to and including termination for violation of these policies or requirements.

Managers shall assist the Compliance Officer in identifying areas that require training and in carrying out the training.

Managers and supervisors will be sanctioned for failing to adequately instruct their subordinates or for failing to detect noncompliance with applicable policies and legal requirements where reasonable diligence on the part of the manager or supervisor would have led to the discovery of problems or violations and given the Home Health Agency the opportunity to correct them earlier.

Active clinical staff shall participate in educational programs focusing on billing and the need for thorough, precise and timely documentation of services.

The Compliance Officer shall maintain records of employee training, including attendance logs and material distributed at training sessions.

The Compliance Officer shall establish a procedure for employees and others to submit questions about, or request clarification of, any compliance issues. If appropriate, the Compliance Officer shall share the questions and answers with appropriate employees, directors, medical staff appointees and others.

**F. COMMUNICATION**

An open line of communication between the Compliance Officer and Home Health Agency employees will be maintained. Any employee or agent who has knowledge of activities that he or she believes may violate the law has an obligation, promptly after learning of such activities, to report the matter to his or her immediate supervisor, to the Compliance Officer or to the Chief Executive Officer. Reports may be made anonymously and without fear of retribution. Every effort will be made to keep reports confidential but there may be instances where the identity of the individual making the report will have to be revealed. The process for reporting suspected violations to the Compliance Officer will be part of the education and/or orientation for all employees.

Employees may seek clarification from the Compliance Officer or the Compliance Committee of any policy or procedure. Requests for clarification and answers shall be documented, dated and, if appropriate, shared with other employees.

Employees will be asked during annual performance reviews and during exit interviews whether they are aware of any potential misconduct or suspected violations of Home Health Agency policies and procedures or federal or state laws or regulations.

**G. DISCIPLINARY ACTIONS**

Individuals who fail to comply with the Home Health Agency's compliance policies and/or federal or state laws or who have otherwise engaged in wrongdoing that has the potential of impairing the Home Health Agency's status as a reliable, honest, trustworthy provider will be subject to discipline in accordance with applicable personnel procedures, which could include termination.

Failure to report known violations, failure to detect violations due to negligence or reckless conduct and making false reports shall be grounds for disciplinary action, including termination.

**H. AUDITING AND MONITORING****1. Periodic Audits**

Regular, periodic audits of Home Health Agency operations will be conducted under the direction of the Compliance Officer, with particular attention paid to the Home Health Agency's compliance with laws governing kickback arrangements, the physician self-referral prohibition, claim development and submission, reimbursement, marketing, cost reporting and record-keeping. Such audits shall also review specific rules and policies that have been the focus of attention on the part of fiscal intermediaries and the government.

Audits shall be conducted by individuals who are independent of line management and who have access to existing audit resources, relevant personnel and all relevant areas of operation. Audit procedures shall include, at a minimum:

- (a) visits and interviews of patients in their homes;
- (b) analysis of utilization patterns;
- (c) testing clinical and billing staff on their knowledge of reimbursement coverage criteria and official coding guidelines (e.g., present hypothetical scenarios of situations experienced in daily practice and assess responses);
- (d) assessment of existing relationships with physicians, hospitals, and other potential referral sources;
- (e) unannounced mock surveys, audits, and investigations;

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- (f) reevaluation of deficiencies cited in past surveys for Medicare conditions of participation;
- (g) examination of complaint logs;
- (h) checking personnel records to determine whether any individuals who have been reprimanded for compliance issues in the past are among those currently engaged in improper conduct;
- (i) interviews with personnel involved in management, operations, claim development and submission, patient care, and other related activities;
- (j) questionnaires developed to solicit impressions of a broad cross-section of the Home Health Agency's employees and staff;
- (k) interviews with physicians who order services provided by the Home Health Agency;
- (l) reviews of clinical documentation (e.g., plan of care, nursing notes, etc.), financial records, and other source documents that support claims for reimbursement and Medicare cost reports;
- (m) validation of qualifications of physicians who order services provided by the Home Health Agency;
- (n) evaluation of written materials and documentation outlining the Home Health Agency's policies and procedures; and
- (o) trend analyses, or longitudinal studies that uncover deviations, positive or negative, in specific areas over a given period.

### **2. Reports to Compliance Committee and Others**

At least annually, a written report on compliance activities shall be presented to the Compliance Committee, the Chief Executive Officer, and the governing body. The report shall identify areas where corrective actions are needed and shall be used by the Compliance Officer and management to correct problems and prevent them from recurring. Subsequent audits will be performed to ensure that corrective actions have been implemented and are successful.

### **3. Requests for Advice from Government Agency**

The Compliance Officer shall document any request for advice from a government agency charged with administering a federal health care program (including a Medicare fiscal intermediary or carrier). The response, whether oral or written, shall also be documented along with the determination of the Compliance Officer as to whether reliance on such advice is reasonable and any efforts to develop procedures based upon such advice.

### **I. VIOLATIONS AND INVESTIGATIONS**

- 1. Any report or evidence of a suspected violation of law, regulations or applicable standards of conduct shall be forwarded to the Compliance Officer who shall review the report or evidence and determine whether there is any basis to suspect that a violation has occurred.
- 2. If the Compliance Officer determines that a violation may have occurred, the matter shall be referred to outside legal counsel who, with the assistance of the Compliance Officer, shall conduct a more detailed investigation which may include, but is not limited to, the following:
  - (a) interviews with individuals who have knowledge of the facts alleged;
  - (b) a review of documents;
  - (c) legal research and contact with governmental agencies for the purpose of clarification.
- 3. A log shall be kept of all reports of possible misconduct that indicates the nature of any investigation and its results.
- 4. Any reports to an outside agency shall be made pursuant to the Home Health Agency's Policy on Reporting to Outside Agencies.

### **J. NEW EMPLOYEE POLICY**

Each applicant for employment in the Home Health Agency shall complete an application form that requires the applicant to disclose any criminal conviction related to controlled substances, health care fraud, patient abuse or the Medicare or Medicaid program and any exclusion from participation in the Medicare or Medicaid program. A reference check shall be performed on each applicant including a review of the Cumulative Sanction Report. No individual who has been convicted of a crime listed above or who has been excluded from the Medicare or Medicaid program shall be hired.





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**IMPORTANT NOTICE**

Before distributing the Corporate Compliance Policy to Home Health Agency employees and asking them to sign the attached "Acknowledgment of Receipt," please consult with labor counsel, especially if the Home Health Agency is subject to a collective bargaining agreement.

Some employees have refused to sign the form, arguing that the terms of the Corporate Compliance Policy, particularly those provisions relating to disciplinary action and the duty to report suspected violations, are subject to negotiation with the union representing them.

The purpose of distributing the Corporate Compliance Policy and requesting employees to sign the acknowledgment form is to demonstrate that the Home Health Agency has made a good faith effort to inform employees regarding the Home Health Agency's Corporate Compliance Program. That objective can also be attained by having supervisors sign an attestation that they have distributed the Corporate Compliance Policy to all employees for whom they are responsible.

This also emphasizes the importance of having a well-developed educational program in place before announcing the Corporate Compliance Program and distributing the policy. An educational session presented by the Corporate Compliance Officer, or by supervisors after they have been educated about the Corporate Compliance Program, gives employees an opportunity to ask questions and helps to allay fears about job security or their responsibilities under the program.

**ACKNOWLEDGMENT OF RECEIPT OF CORPORATE COMPLIANCE POLICY**

I have received a copy of the Corporate Compliance Policy. I have also received and read policies and standards of conduct applicable to my position. I agree to comply with them. I acknowledge that I have a duty to report any suspected violations of law or of the standards of conduct to my immediate supervisor, the Compliance Officer or the Chief Executive Officer.

X

Signature of Employee

X

Printed or Typed Name

Date: X