



Community Policy

Self-Employed Providers

All Self Employed Third-Party Healthcare Providers and Self Employed Non-Healthcare Vendors must comply with the following requirements set forth by community management.

Failure to meet the below requirements within 30 days of account creation may result in denied access to the community and/or interruption in service.

Simple 3–Step Compliance

1. Create an Account at the Accushield Kiosk

- a) Enter your **mobile number** to create a “Unique User Account” & receive pertinent messages to avoid interruption in service, such as retrieving your PIN
- b) Enter your **Known Legal Name**, as it would appear in official documents
- c) **Do NOT** enter a company name, but check the “Self-employed” bubble below. If your company cannot be found, **spell out your complete company name**.
- d) Follow prompts in Accushield Kiosk to complete Initial Account Registration

2. Complete the Registration Packet and Return to Accushield

- a.) E-mail to: support@accushield.com
- b.) Fax to: (404) 382-7229

3. Submit Payment by Visiting www.accushield.com to Access Accushield’s Payment Page

The fee is for the **collection, validation and management** of credentials and visit information per the community’s request. See more details at www.accushield.com

**All documents listed below are REQUIRED to meet current community standards.
Do NOT submit portions of requirements without current contact information
(i.e. phone # and/or e-mail)**

Required Documents:

- 1.** Registration Form (Completed one time, until information changes, page 3)
- 2.** Signed Consent for Use of Information (Completed one time, page 7)
- 3.** Signed Healthcare Provider and other Vendor Agreement (page 9)
- 4.** Payment Instructions (Completed one time, page 13)
- 5.** Criminal Background Check (See detailed instructions, page 4)
- 6.** Proof of Negative TB (See detailed instructions, 5)

Community standards are detailed in the following pages.

Registration Form

Please fill out ALL fields carefully for accuracy and speed of service.

•Contact Name of the Person Who Hired You; Their Relationship to Resident (please print):

•Provider Name: _____

•Mobile Phone Number: _____

•Fax Number: _____ •Email: _____

•Contracted by an Agency? If Yes, Print Name: _____

List ALL Accushield Partner Communities in which you are active:

•Community Name: _____ •State: _____

•Community Name: _____ •State: _____

•Community Name: _____ •State: _____

•Community Name: _____ •State: _____

•Community Name: _____ •State: _____

•Community Name: _____ •State: _____

•Community Name: _____ •State: _____

Service Type (Check All That Apply):

Doctor

DME

Home Care

Home Health

Hospice

Marketer

Maintenance

Nurse/PA

Private Duty Sitter/Provider

Other: _____

Community Standards for Third-Party Providers

A. Criminal Background Check

The background check needs to include the following information:

1. State and local check based on 7-year address history
 2. Federal Sex Offender Database check
- **In the state of California, the California LiveScan results will suffice.**

DO NOT INCLUDE Social Security Numbers and Driver License Numbers on any documents submitted to Accushield **directly**.

We accept a criminal background check from any reputable third-party service, AS LONG AS it meets the community standards listed above.

If you need a Criminal Background Check:

A volume discount has been negotiated with MLQ Attorney Services to conduct an adequate background check. A release form for MLQ Background Services is included in this packet and should be submitted **directly** to MLQ if you choose to use their services.

Note:

MLQ is unaffiliated with Accushield, and independently operated. For processing and accurate pricing information, please contact MLQ at:

EMAIL ORDERS@MLQAS.COM / PHONE 800-446-8794

B. Proof of Negative TB (Tuberculosis Skin Test a.k.a. PPD, Mantoux, TST)

- Must be submitted annually (The Certificate may be issued by an MD, DO, RN, APRN, or PA).
- Must include the date of administration and reading of the PPD (The measurement in millimeters of the induration) and
- Must include the signature or stamp of the MD, DO, RN, APRN, PA, or clinic.
- In the case of positive test results:
 - a. You will need to submit one clear x-ray result (valid for five (5) years)
 - b. AND a statement (letter or form) from your physician that you are free of TB symptoms.
 - c. The Symptom Check Sheet need to be updated and submitted annually starting AFTER one (1) year of original X-ray submission.
 - d. **Please DO NOT fax actual X-ray.**
- We also accept negative results of Interferon Gamma Release Assay (IGRA) testing.
- We do not accept the BCG vaccine in lieu of the negative TB test results.



DO NOT SUBMIT TO ACCUSHIELD

PERMISSION AND RELEASE FORM FOR A BACKGROUND INVESTIGATION

 (NAME) FIRST, MIDDLE, LAST MAIDEN/FORMER NAMES
 7 YEAR ADDRESS HISTORY: (use additional sheet if necessary) MALE _____ FEMALE _____

 (CURRENT ADDRESS) NUMBER, STREET, CITY/TOWN, STATE, ZIP CODE HOW LONG AT THIS ADDRESS

 (PREVIOUS ADDRESS) NUMBER, STREET, CITY/TOWN, STATE, ZIP CODE HOW LONG AT THIS ADDRESS

 (PREVIOUS ADDRESS) NUMBER, STREET, CITY/TOWN, STATE, ZIP CODE HOW LONG AT THIS ADDRESS

 (PREVIOUS ADDRESS) NUMBER, STREET, CITY/TOWN, STATE, ZIP CODE HOW LONG AT THIS ADDRESS

 DATE OF BIRTH PLACE OF BIRTH SOCIAL SECURITY NUMBER

 DRIVERS LICENSE STATE DRIVERS LICENSE NUMBER

IN CONNECTION WITH PERFORMING SERVICES AT CERTAIN SENIOR LIVING COMMUNITIES, I HEREBY AUTHORIZE ACCUSHIELD, LLC AS AGENT FOR SUCH COMMUNITIES, AND ANY AUTHORIZED AGENTS ACTING ON ITS BEHALF, INCLUDING MLQ ATTORNEY SERVICES, TO PREPARE AN INVESTIGATIVE REPORT ON MY BACKGROUND INCLUDING A SOCIAL SECURITY TRACE FOR ADDRESS VERIFICATION. I THEREFORE AUTHORIZE, REQUEST AND REQUIRE ANY PERSONS OR INSTITUTIONS CONTACTED TO FURNISH MLQ ATTORNEY SERVICES, OR ITS AGENTS, ANY INFORMATION THEY HAVE CONCERNING ANY CRIMINAL RECORDS, MOTOR VEHICLE RECORDS, DRUG SCREENINGS, MY WORK HISTORY AND ACHIEVEMENTS, EDUCATION HISTORY AND ACHIEVEMENTS, AND GENERAL REPUTATION AND CHARACTER.

AS AN INDUCEMENT TO PROVIDE THIS INFORMATION, I HEREBY RELEASE AND FOREVER DISCHARGE EACH AND EVERY SUCH PERSON OR INSTITUTION FROM ANY AND ALL CLAIMS OF LIABILITY IN LAW OR IN EQUITY THAT MAY ARISE OUT OF FURNISHING SUCH INFORMATION TO MLQ ATTORNEY SERVICES, OR ANY AUTHORIZED AGENT OF THAT COMPANY.

I MAY, UPON WRITTEN REQUEST, RECEIVE FURTHER INFORMATION AS TO THE NATURE AND SCOPE OF SUCH INVESTIGATION. ANY INQUIRIES ARE TO BE DIRECTED TO ACCUSHIELD, LLC.

MY SIGNATURE BELOW INDICATES MY UNDERSTANDING AND ACCEPTANCE OF ALL THE ABOVE TERMS AND STIPULATIONS.

 SIGNATURE DATE
 MY CONTACT INFORMATION: EMAIL _____ PHONE NUMBER: _____

REQUIRED TO COMPLETE REQUEST

 (COMPLETED BY MLQ ATTORNEY SERVICES)
 PLEASE CHECK REQUESTED INFORMATION:
 MVR _____ PRE-EMPLOYMENT VERIFICATION _____
 CRIMINAL HISTORY: _____ STATE(S) _____
 OTHER: PLEASE LIST _____
 PERSON TO CONTACT: _____ PHONE NUMBER _____ EXT _____
 EMAIL ADDRESS: _____

Consent for Use of Information

Please Fill in All Blanks

This Accushield Consent for Use of Protected Information (this “Accushield Consent”) is entered into and effective as of this date _____, 20____ (the “Effective Date”) by and between Accushield, LLC (“Accushield”), and the individual identified below.

I, _____, give my full consent to Accushield, under this Accushield Consent, to use, store, and maintain in its private and cloud-based encrypted database (defined below) any and all documents and related information I provide to Accushield and/or authorize Accushield to obtain (the “Information”) regarding myself or contractors or employees working on my behalf, including, but not limited to, the following:

- Criminal Background Check
- Proof of Negative TB or chest X-ray
- Accushield Consent and Release/Authorization Forms
- Applicable Accushield Registration Forms
- Employment Verification Form (if applicable)
- Other Community Specific Requirements

Further, I authorize Accushield to view my Information in whatever form transmitted to Accushield.

I specifically authorize Accushield to consult with or obtain my Information from a third party that has access to or the ability to provide such Information.

I understand that this Information may be viewed by authorized users of the Accushield system who are provided a secure username and password.

I hereby certify that all Information provided by me is true and accurate to the best of my knowledge, and I agree to inform Accushield of any new developments or changes with respect to the Information provided as soon as practicable after such change or development.

I acknowledge that this is an “online” private and encrypted database storage system of the above Information.

I understand that Accushield has adopted reasonable measures to secure and protect this Information while in transit and stored, but I accept the inherent risk of malicious infiltration of the Accushield system and will not hold Accushield responsible for any harm if this Information is accessed by any third party, damaged or lost.

I reserve the rights to access and change at any time this Information.

I understand that I can delete any-and-all Information by emailing support@accushield.com or by calling the Accushield helpline at (800) 478-5085.

I acknowledge that I must include my Verification Information with my request.

For purposes of this Consent, "Verification Information" means, collectively:

1. My Account Name;
2. The Mobile Number I use for sign in at Accushield's kiosk; and
3. My personal identification number ("PIN").

I hereby release from liability and agree to hold harmless Accushield and its affiliates, employees, agents and representatives for the acts or omissions performed in connection with my Information.

I agree that by signing this Accushield Consent, I will not do the following:

- Provide Accushield with any sensitive information that is beyond the scope of Accushield's request such as, but not limited to, any Social Security Numbers and Driver's License Numbers.
- Provide Accushield with any unrequested personal healthcare information.

By signing this Accushield Consent, I understand and agree to the following:

- This Accushield Consent is valid as long as I am a member of Accushield. I may terminate my membership by calling (800) 478-5085. I understand and agree that in the event my membership with Accushield is terminated, the releases and waivers contained herein shall survive termination of my Accushield membership.
- This Accushield Consent may be executed in one or more counterparts, each of which shall be deemed an original but all of which together will constitute one and the same instrument. A photocopy or facsimile copy of the signed original of this Accushield Consent shall have the same force and effect as the original and shall be sufficient for the same purposes.

By signing below, I agree to be bound by the terms of this Accushield Consent. My signature creates a binding contract and constitutes my assent to the terms of this Accushield Consent. My failure to sign below will result in my not being able to access or otherwise use the Accushield system, Website or related services.

INDIVIDUAL CAREGIVER/VENDOR:

Signature: _____ Name (please print): _____

Provider Agreement

This Provider or Vendor Company Agreement (“Agreement”) is executed by _____ (“Provider”), having principal residence in the State of _____. Accushield, LLC (“Accushield”) operates a vendor credentialing service on behalf of certain entities (each referred to herein as “Company” and, collectively, the “Companies”). Each Company is the owner or operator of a Senior Living Community (each referred to herein as a “Community,” and, collectively, the “Communities”).

Provider intends to provide services to one or more residents at the Community, or to the Community itself (“Work”). In order to provide the Work, Provider requests and requires access to the Community.

NOW THEREFORE, in consideration of Provider being allowed to enter and come upon the premises of any Community, which Provider acknowledges and agrees is valuable consideration, receipt of which is hereby acknowledged, sufficient to support the obligations and agreements undertaken by the Provider herein, Provider hereby agrees to the above and as follows:

1. Disclaimer of Status

It is expressly understood that if Provider has been engaged by one or more residents of one or more Companies, then Provider has not been engaged, directly or indirectly, by such Company. Nothing in this Agreement or otherwise shall be construed to constitute Provider in such situation as an employee, agent or independent contractor of any Company; nor shall anything in this Agreement or otherwise be construed to constitute any Company or Company Personnel as an employee, agent or independent contractor of Provider.

Irrespective of whether Provider is performing Work on behalf of a resident at a Community or is performing Work on behalf of the Company, Provider acknowledges and agrees that such Company is not directing or controlling the Work, nor shall it be deemed to have requested Provider provide any services on behalf of any resident of the Community. As such, Provider acknowledges and agrees that Provider is not entitled to, and will not seek to, recover from any Company or its insurance companies or coverage, including without limitation any Company’s worker’s compensation insurance coverage, for Claims or Losses sustained while at any Community of a Company or providing or performing Work, except to the extent caused directly by such Company’s gross negligence or intentional misconduct. For purposes of this Agreement, “Claims” means any claim, complaint, action, suit, investigation or other proceeding, and “Losses” means any-and-all injuries, losses, damages, liabilities, costs, expenses (including without limitation attorneys’ and experts’ fees and expenses, and other legal expenses), debts, taxes or fines, whether for personal injury or property damage.

2. Waiver

To the full extent allowed by applicable law, Provider hereby waives the right to assert, and agrees not to assert, any Claim against any Company or Accushield, or their respective past, present or future principals, officers, directors, partners, agents, attorneys, accountants, employees, representatives, parents, subsidiaries, sister or affiliated entities, or insurers, or any of the respective successors or assigns (collectively, the “Released Parties”) arising out of or related to: (i) any Losses sustained by Provider while at any Community or arising out of or related to the presence of Provider at any Community; (ii) the performance of the Work; (iii) any and all acts or omissions by any of the Released Parties in connection with the Information of Provider or; or (iv) any third party access, damage or loss relating to the Information of Provider, in all cases including without limitation Claims and Losses resulting from the negligence of any of the Released Parties, but excluding Claims and Losses resulting from gross negligence or intentional misconduct.

3. Confidentiality

- a) Provider shall comply with all applicable federal and state laws and regulations regarding the confidential and secure treatment of individually identifiable health information.
- b) Provider understands and acknowledges that, in connection with entering and coming on the property or premises of any Company, Provider might acquire or be exposed to a Company’s trade secret information, confidential and proprietary information, including but not limited to business plans, product plans, designs, inventions (whether or not patentable), costs, prices, finances, marketing and advertising plans, software, technology and other intellectual property, and information regarding customers, executives and employees. Provider hereby agrees that Provider shall hold such information in confidence and not disclose, distribute, transmit or transfer such information to any person or entity for any purpose other than the performance of such person’s engagement with the Company or its resident, and shall not use such information for any purpose, except as required by applicable law.

4. Use of Information

- a) Provider authorizes Accushield and each Company to view any-and-all documents, credentials, and related information provided by Provider to Accushield or obtained by Accushield with Provider's authorization in whatever form transmitted to Accushield (collectively, the "Information"). Provider specifically authorizes Accushield to consult with or obtain Provider's Information from a third-party that has access to, or the ability to provide, such Information. Provider agrees that this Information may be viewed by authorized users of Accushield's systems who are provided a secure username and password.
- b) Provider hereby certifies that all Information provided by Provider is true and accurate in all material respects. Provider agrees to inform Accushield of any new developments or changes with respect to the Information provided by Provider as soon as practicable after such change or development. Provider acknowledges and agrees that Accushield has no obligation to verify any Information related to Provider.
- c) Provider acknowledges and agrees that, while Accushield has adopted reasonable measures to secure and protect the Information while in Accushield's possession, Provider accepts the inherent risk of storing Information online.
- d) Provider acknowledges and agrees that each Company has established certain requirements to attain a credentialed status with Accushield for purposes of accessing Communities operated by such Company. In the event that the Information does not satisfy a Company's requirements, Provider acknowledges and agrees that Provider may not obtain a credentialed status with Accushield and that, as a result, a Company, at its sole discretion, may limit access to a Community by Provider.

5. Responsibility and Indemnity

Provider shall be responsible for any-and-all Claims and Losses arising out of or related to (a) the Work or any other acts or omissions by Provider while at a Community or otherwise, including without limitation any breach of this Agreement, or (b) the Information of Provider. To the full extent allowed by applicable law, Provider shall indemnify and hold each Released Party harmless, and at the Released Party's option, defend it, from and against any Claim or Loss arising out of or related to the foregoing, except to the extent caused directly by such Released Party's gross negligence or intentional misconduct.

6. Miscellaneous

Neither party may assign this Agreement without the consent of the other, except Accushield may assign this Agreement in connection with a sale of its business, by stock, asset, merger or otherwise. This Agreement shall bind and inure to the benefit of Provider's successors and permitted assigns, and shall inure to the benefit of the Released Parties. This Agreement contains the entire agreement with respect to the subject matter hereof and supersedes all other written or oral statements or agreements heretofore made with respect to the subject matter hereof. Any failure to enforce any provision of this Agreement shall not constitute a waiver thereof or of any other provision hereof. This Agreement may not be amended except in a writing signed by both parties. If any provision hereof is declared invalid by a court of competent jurisdiction, such provision shall be ineffective only to the extent of such invalidity, so that the remainder of that provision and all remaining provisions of this Agreement will continue in full force and effect. Headings of particular sections are inserted only for convenience and are not to be used to define, limit or construe the scope of any term or provision of this Agreement. In this Agreement, the disjunctive "or" shall include the conjunctive "and," and vice versa. Should any provision of this Agreement require judicial interpretation, it is agreed that the court interpreting or construing same shall not apply a presumption or rule that the terms of this Agreement shall be more strictly construed against the drafter. Provider has read this Agreement in its entirety, understands the terms contained herein, has had the opportunity to consult counsel or has elected not to consult counsel, and intends to be bound hereby. The interpretation and enforcement of this Agreement will be governed by the laws of the State of Georgia, without regard to any conflicts of law, rules or provisions.

PROVIDER:

Signature: _____ Name (please print): _____

Date: _____

Payment Instructions

The \$9/month, per individual, for unlimited visits to any Accushield partner community is for the **collection, validation** and **management** of credentials and visit information per the community's request.

www.accushield.com

1. Go to www.accushield.com
2. Select "Pay Here" at the top right of Home Page
3. Follow the prompts

For questions about billing contact:
accounting@accushield.com or call: 1-800-478-5085