Caringhands Home Health Care Inc.

We consider applicants for all positions without any regard to race, color, religion, sex, national origin, age, marital or veteran status, the presence of a non-job related medical condition or handicap, or any other legally protected status.

Last Name _____ Middle Initial _____ First Name _____ SSN #: _____

Current Address _____ City _____

State _____ Zip Code _____ APT _____ Date of Birth: _____ GENDER: ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single Phone #: _____ Driver's Lic. / State ID _____

AUTO INS. POLICY #: _____ EXP. DATE: _____ EXPIRATION DATE: _____

AA/EEO CODE

☐ African American/ Black ☐ Asian/ Pacific Islander ☐ Caucasian ☐ Disabled/ Handicapped

☐ Hispanic/ Latin American ☐ Native American ☐ Other ☐ Unknown

What Position You Are Applying For? _____

AVAILABILITY

Please mark all of the hours you are available for work. Please indicate am or pm

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time							
End Time							

On what date would you be able to start work? _____ Are you currently employed? ☐ YES ☐ NO

Have you filled out an application with us before? ☐ YES ☐ NO If yes, give date: _____

Have you been employed with us before? ☐ YES ☐ NO If yes, give date: _____

Available for: ☐ Temporary ☐ Part-Time ☐ Full-Time

EMERGENCY CONTACT

Name _____ Address _____

City _____ State _____ Zip Code _____ County _____

How did you hear about us? (Please check all that apply)

☐ Employment Agency ☐ Advertisement ☐ Walk-in ☐ Friends or Relatives (If so Name): _____

EMPLOYMENT EXPERIENCE

Please start with your most recent job. Include any job-related military service assignments and volunteer activities. You may exclude organizations which indicate race, color, gender, national origin, handicap, or other protected status

Employer Name

Address

City State Zip Code

Country

Tel. # 1: Tel. # 2:

Job Title

Supervisor

Reason for Leaving

Dates Employed	
From	
To	
Hourly Rate/ Salary	
Start	
Final	
May we contact?	

Employer Name

Address

City State Zip Code

Country

Tel. # 1: Tel. # 2:

Job Title

Supervisor

Reason for Leaving

Dates Employed	
From	
To	
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Employer Name

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Tel. # 1: Tel. # 2:

Job Title

Supervisor

Reason for Leaving

Dates Employed	
From	
To	
Hourly Rate/ Salary	
Start	
Final	
May we contact?	

Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status? (Proof of citizenship or immigration will be required upon employment) ☐ Yes ☐ NO

Have you been convicted of a felony within the last 7 years? (Including sex related or child related offenses ☐ Yes ☐ NO

If yes, please explain:

EDUCATION

HIGH SCHOOL

School Name _____ Years Completed (Check One) ☐ 9 ☐ 10 ☐ 11 ☐ 12

Address/ Location _____ Graduated? ☐ Yes ☐ NO

Describe course of study: _____

COLLEGE/ VOCATIONAL

School Name _____ Years Completed (Check One) ☐ 1 ☐ 2 ☐ 3 ☐ 4

Address/ Location _____ Graduated? ☐ Yes ☐ NO

Describe course of study: _____

ADDITIONAL TRAINING AND SPECIALISATION SKILLS

Please list in-service training, job related skills or special certificates below: (E.g.: CPR, First Aid, Behavior Management, etc.)

_____

REFERENCES

Please provide the name, address, and telephone number of three references who are not related to you

Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone #: _____ Describe Relationship to you: _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone #: _____ Describe Relationship to you: _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone #: _____ Describe Relationship to you: _____

TO ALL APPLICANTS

Caringhands Home Health Care, Inc. is an "AT WILL" employer. "AT WILL" means employees have the right to end their employment without notice. Also, the company reserves the right to terminate employment without reason or notice. This does not include any person who holds contracts for employment or any unfair employment practices

Signature Date

If you are considered for employment, you must meet and sustain the following criteria:

Provide 3 references that must be checked before hire YES NO

Must possess a valid driver's license: YES NO

Possess a vehicle to use at and for work at all times: YES NO

Have automobile insurance YES NO

Clear a criminal background check: YES NO

Driving record checks and background studies are done for all new hires and current employees yearly. Both checks must be rated with a 'CLEAR' status or termination will result. The Department of Human Services requires three reference checks. Employees will have ten (10) days to get these completed or termination will result.

PLEASE NOTE

EMPLOYMENT OR CONTINUED EMPLOYMENT IS CONTINGET ON ALL FACTORS ABOVE

New Employee training is mandatory (4) hours of training are required by the State of Minnesota and the Department of Human Services. No employee may work at any home until orientation and on-site training (Care Plan) has been reviewed by the RN or Qualified Person.

We require that all applicants to complete the new training within two (2) weeks of their hire date (or the first available training class).

I accept this training completion notice and I am able to complete my training in a (2) week period. All

training and meetings are paid at **minimum wage**. This includes all on-going training.

I accept this training completion notice but I am unable to complete my training in the two (2) week period. I understand that training is mandatory and I can complete my training in (time)

Applicants Signature Date

CHILD SUPPORT DISCLOSURE FORM

EMPLOYEE NAME: _____ DATE OF BIRTH: _____

Address _____

SSN #: _____

City _____ State _____ Zip Code _____

County _____

Minnesota State Law requires individuals to disclose information about court-ordered child support obligations when they are hired for employment (Minn. Stat. S 518.611, SUBD. 8

Please answer the following as required by law:

DO YOU OWE COURT-ORDERED CHILD SUPPORT THAT YOUR EMPLOYER IS REQUIRED TO WITH HOLD FROM YOUR INCOME? ☐ YES ☐ NO

If you answered "yes" you must provide the following information for each obligation:

Amount Owed: _____ PER _____ for current support _____

Amount Owed: _____ for arrearages _____

Date of the court order: _____ State _____

MONTH / DATE / YEAR

Name and birthdates of child(ren) for whome support is owed:

Name: _____ DATE OF BIRTH: _____

Name: _____ DATE OF BIRTH: _____

Name: _____ DATE OF BIRTH: _____

Child Support agency where support is to be sent:

EMPLOYEE NAME: _____ Address _____

City _____ State _____ Zip Code _____ Your support account #: _____

I declare that everything I have stated on this form is complete and correct to the best of my knowledge. I hereby authorize my employer to verify the information provided with the public agency responsible for child support enforcement.

PERSUANT TO MINNESOTA STATE STATUTE 518.611, SUBDIVISION 8, all Minnesota employers must ask persons hired on or after August 01, 1987, the following questions:

Do you have court-ordered child support obligations which are required by law to be withheld from income? ☐ YES ☐ NO

If yes, you must disclose the terms of the order including:

Which Minnesota Child Support Agency should receive payment?

Amount Due | Frequency | Date of the court order: | County where order originated:

Date (MONTH / DATE / YEAR) | Employer's Name | Date (MONTH / DATE / YEAR)

Signature | Date

FOR OFFICE USE ONLY

CONTINGENT EMPLOYMENT OFFER DATE: _____ DATE ON-SITE WORK BEGUN: _____

DATE TERMINATED: _____ BCA FILE DATE: _____ HEALTH INSURANCE ELIGIBLE: ☐ YES ☐ NO

INSURANCE ELIGIBLE DATE: _____ INSURANCE FILE DATE: _____

COMMENTS

_____

_____

_____

_____

_____

_____

INTERVIEW/ TEST SCORE: **1** _____ **2** _____