

# APPLICATION FOR EMPLOYMENT

PLEASE PRINT ALL INFORMATION REQUESTED EXCEPT SIGNATURE

APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS

**PLEASE COMPLETE PAGES 1-8.**

**Date** \_\_\_\_\_

Name \_\_\_\_\_

Last                                      First                                      Middle                                      Maiden

Present address \_\_\_\_\_

Number                      Street                      City                      State                      Zip

Telephone (    ) \_\_\_\_\_                      Social Security No \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If under 18, please list age \_\_\_\_\_                      Days/Hours Available to work

Please check ( ✓ ) the position applied for                      Mon \_\_\_\_\_ Tue \_\_\_\_\_

CNA \_\_\_\_\_                      HHA \_\_\_\_\_                      Wed \_\_\_\_\_                      Thur \_\_\_\_\_                      Fri \_\_\_\_\_

Homemaker/Companion \_\_\_\_\_                      Live-In \_\_\_\_\_                      Sat \_\_\_\_\_                      Sun \_\_\_\_\_

How many hours can you work weekly? \_\_\_\_\_                      Can you work overnights? YES \_\_\_ NO \_\_\_

Employment desired ~Full-time ONLY \_\_\_ ~Part-time \_\_\_ ~Full or Part-time \_\_\_ ~Weekends only \_\_\_

When are you available to begin work? \_\_\_\_\_

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION <small>Complete mailing address</small>	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School				
College				
Business/Trade School				
Professional School				

If hired, can you provide evidence of legal eligibility to work in the U.S.?           **YES**           **NO**

Any offer of employment is conditional upon completing form I-9 and providing the appropriate documents for identity and work authorization.

1a.

# PLEASE DO NOT WRITE HERE

## FOR OFFICE USE ONLY

Full Time

Part Time

Per Diem

CNA      HHA      Homemaker/Comp      How long?      Active      Lapsed

Drive   Y   N      Car   Y   N

Pets   Y   N      Smoke   Y   N      Food   OK      Allergies \_\_\_\_\_

Hoyer   Y   N      Manual   Electric   Both      Clinical   Facility   Private      Slide Board   Y   N

Exp. w/ Alz-Dementia Clients      Y   N      Clinical   Facility   Private

PPD-   Y   N      Chest x-ray      Y   N      What languages do you read, write & speak fluently?

Are you working now?   Y   N      Monday-Friday what are hours are you interested in working?

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

Weekends   Y   N      Saturday      Sunday      Overnights   Y   N

Holidays   Y   N

Are you available to work in your area to pick up hours on short notice?

Do you have any limitations that you would like to share with us?

Towns/City


What are your goals in the job?

We have a number of applications to review... tell me why yours should stand out and why we should hire you?

2

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SIGNATURE

### APPLICATION FOR EMPLOYMENT

DO YOU HAVE A VALID DRIVER'S LICENSE? YES \_\_\_ NO \_\_\_

Driver's license number \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_

Operator \_\_\_ Commercial (CDL) \_\_\_ Chauffeur \_\_\_

What is your means of transportation to work? \_\_\_\_\_

Have you had any accidents during the past three years? YES \_\_\_ NO \_\_\_ How many? \_\_\_\_\_

Have you had any moving violations during the past three years? YES \_\_\_ NO \_\_\_ How many? \_\_\_\_\_

Please list two references other than relatives or previous employers.

Name _____	Name _____
Relationship _____	Position _____
Address _____	Address _____
_____	_____
Telephone (____) _____	Telephone (____) _____

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An application form sometimes makes it difficult for an individual to adequately summarize a complete background. Use the space below to summarize any additional information to describe your full qualifications for the specific position for which you are applying.

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### EMPLOYEE EMERGENCY CONTACT INFORMATION

"YOUR" Email Address \_\_\_\_\_ @ \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

APPLICATION FOR EMPLOYMENT

Military

HAVE YOU EVER BEEN IN THE ARMED FORCES? YES \_\_\_\_\_ NO \_\_\_\_\_

ARE YOU NOW A MEMBER OF THE NATIONAL GUARD? YES \_\_\_\_\_ NO \_\_\_\_\_

Specialty \_\_\_\_\_ Date Entered \_\_\_\_\_ Discharge Date \_\_\_\_\_

WORK EXPERIENCE~~~~Please list your work experience for the past five (5) years beginning with the most recent job held. If you were self employed, give firm name. Attach additional sheets if necessary.

Employment Dates From \_\_\_\_\_ To \_\_\_\_\_

Name of Employer \_\_\_\_\_ Name of Supervisor \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Your last job title \_\_\_\_\_

Reason for leaving (be specific)

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.

Employment Dates From \_\_\_\_\_ To \_\_\_\_\_

Name of Employer \_\_\_\_\_ Name of Supervisor \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Your last job title \_\_\_\_\_

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.

# APPLICATION FOR EMPLOYMENT

**WORK EXPERIENCE~~~continued. List your work experience for the past 5 years beginning with the most recent.**

Employment Dates From \_\_\_\_\_ To \_\_\_\_\_

Name of Employer \_\_\_\_\_ Name of Supervisor \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Your last job title \_\_\_\_\_

Reason for leaving ( be specific)

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company

Employment Dates From \_\_\_\_\_ To \_\_\_\_\_

Name of Employer \_\_\_\_\_ Name of Supervisor \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Your last job title \_\_\_\_\_

Reason for leaving (be specific)

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.

May we contact your present employer? YES \_\_\_\_\_ NO \_\_\_\_\_

Did you complete this application yourself? YES \_\_\_\_\_ NO \_\_\_\_\_

If not, who did? \_\_\_\_\_

APPLICATION FORM WAIVER

In exchange for the consideration of my job application by Guardian Angels Homecare (hereinafter called "the Company"), I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements, and the like as they may exist from time to time, or other Company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of Guardian Angels Homecare., or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the President/General Manager of the Company. Both the undersigned and Guardian Angels Homecare may end the employment relationship at any time, without specified notice or reason. If employed, I understand that the Company may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. I hereby give the Company permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release the Company from any liability as a result of such contract.

I also understand that (1) the Company has a drug and alcohol policy that provides for pre-employment testing as well as testing after employment; (2) consent to and compliance with such policy is a condition of my employment; and (3) continued employment is based on the successful passing of testing under such policy.

I understand that, in connection with the routine processing of your employment application, the Company may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics, and mode of living. Upon written request from me, the Company, will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act.

I further understand that my employment with the Company shall be probationary for a period of sixty (60) days, and further that at any time during the probationary period or thereafter, my employment relation with the Company is terminable at will for any reason by either party.

This Company is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with this Company depends solely on your qualifications.

Thank you for completing this application form and for your interest in our business.

→ Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

My signature certifies I have not been convicted of a crime involving violence or dishonesty in a state or federal court in any state, or was a subject to any decision imposing disciplinary action by a licensing agency in any state, the District of Columbia, a United States possession or territory or a foreign jurisdiction. It also signifies I am fit and able to carry out my duties and in good health.

Additionally, I understand as an employee of GUARDIAN ANGELS HOMECARE I must abide by the dates & times of service I'm given by the office in order to be paid for my services. I cannot alter either date of service scheduled or time without approval from the office and or case manager, if a State client is involved.

I also understand that I am strictly forbidden from discussing any information regarding my clients, their financial or medical circumstances to anyone for any reason-that all information regarding my clients is confidential and covered by Privacy Laws. I am also forbidden from disclosing any information regarding my client to another employer, or potential employer, and nor am I allowed to approach the client directly to solicit business from this person either for myself or another Agency.

I am not able to accept gifts, gratuities or otherwise from any client. I understand and acknowledge I do not involve myself in my client's finances or handle money under any circumstance. Guardian Angels Home Care is a non-medical provider and I am not able to dispense Rx of any kind and have no authorization from the company to do so.

I understand I am required to notify the office for any time off that I need, and to give a two week notice upon my leaving. Upon leaving I have 2 weeks to turn in any timecards for payroll or I forfeit claim to proceeds from them.

I understand that I am required to have a valid drives license and valid car insurance during the entire duration of my employment with Guardian Angels Home Care. I also understand that if at any I point I allow one or both of these to expire that I release GAHC of any and all liability. I also understand that I must provide a copy of my current driver's license and current car insurance to GAHC. Failure to comply could result in disciplinary action or termination.

I will call the office during regular office hour at 203-439-7731 or 877-439-7731 ext. 201 to notify them if I am unable to make my shift at least 24 hrs in advance. On weekends during regular hours I will call 203-439-7731 or 1877-439-7731 ext 201. **After hours** I will call 203-439-7731 or 877-439-7731 extension 181 to notify the on-call person of my anticipated absence so they can find a replacement if possible.

➔ Signed by \_\_\_\_\_ Date \_\_\_\_\_

Employment Screening

APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

Guardian Angels HomeCare, LLC requires, as a condition of employment, and/or continued employment, that all applicants consent to and authorize a verification of the information submitted on their application or resume. Please read this statement carefully.

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of employment is true and complete to the best of my knowledge. I understand that if I am employed, any false statements will be considered as cause for possible dismissal.

This release and authorization acknowledges that this Company may now, or at any time while I am employed, conduct a verification of my education, employment history, three (3) years of drug, alcohol and accident history from all Departments of Transportation (DOT)-regulated employers, credit history, and motor vehicle records. In addition this company may contact personal references, require that I provide a urine specimen to be tested for the presences of drugs or alcohol, and receive any criminal history record information pertaining to me which may be in the files of any Federal, State or Local criminal justice agency in any state, and/or information as deemed necessary to fulfill the job requirements.

I authorize Guardian Angels HomeCare and any of its agents and/or employees to disclose verbally and in writing the results of this verification process to the designated authorized representative of the Company. The results will be used to determine employment eligibility under this Company's employment policies.

I have read and understand this release and consent, and I authorize the background verification. I authorize persons, schools, current and former employers, and other organizations and Agencies to provide Guardian Angles HomeCare with all information that may be requested, and I hereby release all of the persons and agencies providing such information from any and all claims and damages connected with their release of any requested information. I agree that any copy of this document is as valid as the original.

I do hereby agree to forever release and discharge this Company, its agent, and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, or any other charge or complaint files with any agency arising for the retrieving and reporting of information. According to the Federal Fair Credit Reporting Act, I am entitled to know if the employment was denied based on information obtained by my prospective employer, and to receive, upon written request, a disclosure of the public record information and of the nature and scope of the investigative report. If I am a resident of Minnesota, California or Oklahoma only and would like a copy of the investigative report, I will check here [ ]

Please provide all requested information and provide address for the last seven -(7) years

\_\_\_\_\_(Applicant's Name, Printed- Last, First, Middle) Maiden or Other Name(s) Used

\_\_\_\_\_(Current Address - Street, City, State, Zip) (How Long)

\_\_\_\_\_(Previous Address- City, State, Zip) (How Long)

\_\_\_\_\_(Previous Address-City, State, Zip) (How Long)

(Date of Birth-for confirmation of ID only) \_\_\_\_\_ (Social Security Number) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(Name exactly as it appears on Driver's License) (Drivers License Number) (State)

[ ] Yes [ ] No

(Authorization to contact present employer for reference)

➔ Signature) \_\_\_\_\_ Date \_\_\_\_\_



# PLEASE READ CAREFULLY

## Homemaker/Companions

### Duties and Responsibilities


As a Homemaker/Companion caregiver you will report to the Care Coordinator

All Homemakers and Companions interface with the client in the client’s home or within a facility for care.

Limitations set for each of these duties by CCCI are **strictly enforced** as a company policy and states **no hands-on care is to be provided**. Caregivers acknowledge by their signature on this form they have read CCCI’s hand out regarding the duties and the limitations.

Additionally, as a company, GAHC policy states no caregiver is to provide any medication, herbs, home remedies, vitamins, supplements, make exercise recommendations, alter diets, or handle client’s funds in any way

Caregiver acknowledges they have read and understand their duties and legal limitations. The caregiver also acknowledges they have no previous personal and medical history to prevent them from performing the duties assigned.

 *Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

### Acceptance Of Priority Clients

GAHC has certain clients that are categorized as **Priority Clients**.

These clients cannot be left alone and all their work shifts **MUST** be covered. If you are offered and you accept a Priority Client as an hourly or Live IN caregiver you must give the office a minimum of 24 hours notice when you cannot make a shift or you may be subject to disciplinary action which could include Termination.

### Clients that have Live In caregivers are all considered Priority Clients.

Your signature on this form is your acknowledgement, understanding, and agreement of this policy and that our “call out after hour’s system” has been explained to you so that you understand how to use it and the hours of operation.

 *Signature* \_\_\_\_\_ *Date* \_\_\_\_\_