5200 Helen Ave Unit 1 Jennings, MO 63136
Phone: (314) 553-0552 Fax: (314) 553-0553
www.strategichomehealthcare.com

EMPLOYMENT APPLICATION FOR PERSONAL CARE ATTENDANT

(Please Select) □ **Work For A Specific Person** □ **Be Referred To Others**

Please print clearly
Date ____/____/_____

Last Name: _____ First: _____ Middle: _____

Maiden Name: _____ Are you at least 18 years old? ☐ **Yes** ☐ **No**

Social Security No.: _____ Date of Birth _____

Please disclose all aliases and Social Security Numbers used by applicant:

Social Security No.: _____ Names: _____

Address: _____ City _____ State ____ Zip _____ Telephone: ____ - ____ -_____

Email: _____ *Have you lived in Missouri for the last five years?* ☐ **Yes** ☐ **No**

If No, please list the state you lived in. _____

You are able to meet the physical and mental demands required to perform specific tasks for the consumer? ☐ **Yes** ☐ **No**

Is there any reason why you would not be able to perform the job duties? ☐ **Yes** ☐ **No**

If Yes, please explain below:

_____

_____

_____

You agree to maintain confidentiality? ☐ **Yes** ☐ **No**

You are emotionally mature and dependable? ☐ **Yes** ☐ **No**

You are able to handle emergency situations? ☐ **Yes** ☐ **No**

You are not the consumer's spouse? ☐ **Yes** ☐ **No**

Are you the consumer's spouse? ☐ **Yes** ☐ **No**

Do you agree to keep all of the consumer's information confidential? ☐ **Yes** ☐ **No**

EMPLOYMENT DESIRED

Preferences and Availability:

Do you prefer working with males, females or either? _____

How many hours are you available for work per week? _____ Are you available for night shifts ☐ Yes ☐ No

☐ Full-time ☐ Part-time If "Part time", hours desired: _____ Desired Salary _____

Date available to start: _____ Day/Hours available to work?

Mon: ____ Thurs: ____ Sun: ____
Tues: ____ Fri: ____
Weds: ____ Sat: ____

EDUCATION

	Name of School	Location (Mailing address)	Number of years completed	Major and Degree Completed
High School				
College				
Technically College				

Type of Skilled License/Certification

List any special skills or qualifications which you posses and feel are relevant to health care and the position for which you are applying.

_____
_____
_____

*If you are hired for the position of Personal Care Attendant (**PCA**), a background screening via the Family Care Safety Registry (**FCSR**) must be conducted prior to your first day of employment. Please read the following questions carefully and respond truthfully and fully.*

*I give **Strategic Home Health Care** my consent to conduct a pre-employment criminal record check.* ☐ **Yes** ☐ **No**

If NO, please explain:

_____
_____

*I authorize **Strategic Home Health Care** to conduct a closed record check pursuant to Section 610.120, RSMo* ☐ ***Yes*** ☐ ***No***
If NO, please explain:

_____
_____

Are you registered with the Family Care Safety Registry? ☐ **Yes** ☐ **No**
Have you applied for a Good Cause Waiver? ☐ **Yes** ☐ **No**
If YES, When? _____

DRIVER'S LICENSE *(Only for positions which require driving)*

Do you have a driver's license? ☐ **Yes** ☐ **No**

Driver's license number _____ State of issue _____

☐ Commercial (CDL) ☐ Chauffeur

Expiration date ____/____/____

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? ____

APPLICATION FOR EMPLOYMENT

Please print clearly

(Note: No applicant will be denied employment solely on the grounds of conviction of a criminal offense. The nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense to the position(s) applied for may, however, be considered.) Disclosure of all criminal convictions, finding of guilt, pleas of guilty, and pleas on nolo contender except minor traffic offenses.

Have you ever been convicted of felony? ☐ **Yes** ☐ **No**

Please disclose all criminal convictions, findings of guilt, pleas of guilt, and pleas of nolo contendere or provide a statement that there is no record of such background. Failure to disclose any criminal information is a violation of the law.

If YES, Please LIST <u>ALL OFFENSES</u> and the Dates of each Crime:

_____
_____
_____
_____
_____
_____
_____
_____

Have you ever been convicted of a criminal offense (felony or serious misdemeanor)? (Convictions for marijuana-related offenses that are more than two years old need not be listed.) ☐ **Yes** ☐ **NO**

If yes state nature of the crime(s), when and where convicted and disposition of the case.

_____

_____

Are you now, or have you ever been under investigation, suspended or excluded from participation in the Medicare/Medicaid Programs or other state and/or federal programs? ☐ **Yes** ☐ **No**

If yes state nature of the incident, when and where the incident took place and outcome.

_____

_____

Are you a United States citizen or do you have an entry permit which allows you to lawfully work in the U.S.? ☐ **Yes** ☐ **No**
If applicable, Visa Type: _____ Immigration No: _____

Are you ineligible to be employed with a Missouri licensed health care entity as a result of being found guilty by a court of law for abusing, neglecting, or mistreating individuals in a health care related setting? ☐ **Yes** ☐ **No**

If "Yes," please explain: _____

Are you able to perform all of the duties required by the position for which you are applying, without endangering yourself or compromising the safety, health, or welfare of the Clients or other Staff Persons? ☐ **Yes** ☐ **No**

If "No," please explain: _____

APPLICATION FOR EMPLOYMENT

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Please give accurate and complete information. Start with present or most recent employer.

May we contact and communicate with your present employer? ☐ **Yes** ☐ **No**

Employer____ Telephone No. ____ - ____ -______

Address____ Employed from ____/____/____ to____/____/_____

Name of Supervisor_________________________________ Hourly Wage: Start_____ End_____

Position and Responsibilities: ____

Reason for Leaving: ____

Employer____ Telephone No. ____ - ____ -______

Address____ Employed from ____/____/____ to____/____/_____

Name of Supervisor_________________________________ Hourly Wage: Start_____ End_____

Position and Responsibilities: ____

Reason for Leaving: ____

Employer____ Telephone No. ____ - ____ -______

Address____ Employed from ____/____/____ to____/____/_____

Name of Supervisor_________________________________ Hourly Wage: Start_____ End_____

Position and Responsibilities: ____

Reason for Leaving: ____

Strategic Home Health Care is an equal opportunity employer and upholds the principles of equal opportunity employment. It is the policy of Strategic Home Health Care to provide employment, compensation and other benefits related to employment based on qualifications and performance, without regard to race, color, religion, national origin, age, sex, veteran status or disability, or any other basis prohibited by federal or state law. As an equal opportunity employer, Strategic Home Health Care intends to comply fully with all federal and state laws and the information requested on this application will not be used for any purpose prohibited by law. Disabled applicants may request any needed accommodation. This application is intended to allow you, the applicant, to provide Strategic Home Health Care with the information and data so that your suitability and qualifications can be fairly determined for the position(s) for which you are applying. Please complete this application and answer all questions completely.

APPLICATION FOR EMPLOYMENT

Please read the following statements completely and carefully before you initial and sign your name.

The Applicant HEREBY CERTIFIES that the answers given on this Application for Employment, including any statements or answers provided by the Applicant during interview, are true and correct. The Applicant fully authorizes Strategic Home Health Care to contact any references, past and present employers, persons, schools, law enforcement agencies and any other sources of information which may be relevant to the Applicant and this Application for Employment. It is understood and agreed that any misrepresentation, false statement, or omission by the Applicant will be sufficient reason for rejection of the Application for Employment or for dismissal from employment at any time, without recourse or liability to Strategic Home Health Care.

I have read, understand and agree to the above statement.

(Please initial here). _____

The Applicant is hereby informed that the State of Missouri is deemed as an employment-at-will state. Strategic Home Health Care is a Missouri employer; therefore, the Missouri employment-at-will statutes and rules will apply to the employment status of all Strategic Home Health Care. Thus, no representative of the Strategic Home Health Care has the authority to enter into any agreement for employment for any specified period of time and that Strategic Home Health Care will not guarantee employment for anyone. No employment contract is created by virtue of the Applicant being hired by Strategic Home Health Care.

I have read, understand and agree to the above statement.

(Please initial here). _____

If employed, the Applicant agrees to fully abide by all Staff Conduct and Workplace Standards, including professional ethics, safety rules, and a code of conduct for the Strategic Home Health Care. The Applicant understands that the Strategic Home Health Care is committed to maintaining an alcohol and drug-free workplace. Also, if employed, the Applicant realizes that Strategic Home Health Care conducts random drug testing that applies to all employees.

I have read, understand and agree to the above statement.

(Please initial here). _____

Application will remain on file for 90 days for consideration. After 90 days, if the Applicant remains interested in a position with Strategic Home Health Care, it will be necessary for the Applicant to reapply.

I certify that all of the information contained in this application is true and complete and I authorize verification of any or all information presented above.

_____	_____	_____/___/_____
Please Print Full Name	***Attendant Signature***	***Date***

Employee Reference Check Authorization Form

I have applied for employment with Strategic Home Health Care. I hereby request and authorize you to provide Strategic Home Health Care with any information concerning my employeement record. I do hereby release the addressed entity and all individuals concerned from any claims, suit and liabilities for any damage whatsoever resulting from their action and conduct in responding to its request and giving of such information.

Signature: _____
Print: _____
Date: ____/____/____

_____ has applied for an employment opportunity with Strategic Home Health Care and has indicated previous employment with your organization. The information requested will help us to evaluate the application. We will hold your comments in confidence.

Thanks for your cooperation,
Carrie Sanders, Executive Director

Reference Request Form

Subject: Request for person a reference

The above applicant has applied for a position with Strategic Home Health Care and has indicated you as a reference. The information requested below will help us to evaluate the applicant. We will hold your comments in confidence.

Thanks for your cooperation,
Carrie Sanders, Executive Director

Name/Title: _____ Phone: _____

Address: _____ E-mail: _____

Name/Title: _____ Phone: _____

Address: _____ E-mail: _____

Name/Title: _____ Phone: _____

Address: _____ E-mail: _____

I certify that all of the information contained in this application is true and complete and I authorize verification of any or all information presented above.

Employee Reference Check

Date: ____/____/____

Please assist us with employment verification on:

Name: _____ SSN. _____

Employment Verification
Personal Use Only

Company name: _____

Address: _____

Telephone: _____

Signature of person verifying

Employment: _____ Date: ____/____/____

Title: _____

Please indicate the following:

Position held with your company: _____

Employment dates____/____/____ to ____/____/____

Is his/her eligible for rehire? ☐ Yes ☐ No

Please rate the applicant on the basic of his/her employment with your organization:

Excellent, Good, Fair or Poor

Cooperation_____ Job Knowledge_____

Efficiency _____ Attendance _____ Reliability _____

Comments:_____
_____
_____
_____

** We appreciate your prompt response upon completion**