

EMPLOYMENT APPLICATION for HOME CARE WORKER

Personal Information	
Name	First _____ 2 nd Initial _____ Last: _____
Address	Street: _____ Apartment: _____ City: _____ State: _____ Zip: _____
Phone	Home: _____ Cell: _____ Other: _____
Electronic	Email Address: _____
Date of Birth	Day: _____ Month: _____ Year: _____
SIN	Social Insurance Number: _____
Gender	Male: _____ Female: _____
Language	What languages do you speak? _____ _____
Emergency Contact	Name & Phone Number of Person to contact in the event of an emergency: Local: _____ Out-of-Area: _____
Education	
Formal	Diploma: _____ Certificate: _____ Degree: _____ Other: _____ Other: _____

Informal	Do you have current First Aid Certification (State Level): _____ Expiry Date: _____ Do you have current CPR? _____ Expiry Date: _____ Have you taken a Food Safety course? _____ Other: _____ <div style="text-align: center;">(Specify)</div> Other: _____ <div style="text-align: center;">(Specify) </div>
Restrictions	
Work Limitations	List any work limitations that you may have and briefly describe: Hearing: ___ Yes ___ No _____ Speech: ___ Yes ___ No _____ Lifting: ___ Yes ___ No _____ Health: ___ Yes ___ No _____ Physical: ___ Yes ___ No _____ Emotional: ___ Yes ___ No _____ Other: ___ Yes ___ No _____
Availability for Work	
Hours & Days Available for Work	_____ Full-time _____ Part-time _____ Short-notice _____ Split Shift Indicate Days and List Hours Available for Work: _____ Sunday: From: _____ To: _____ _____ Monday: From: _____ To: _____ _____ Tuesday: From: _____ To: _____ _____ Wednesday: From: _____ To: _____ _____ Thursday: From: _____ To: _____ _____ Friday: From: _____ To: _____ _____ Saturday: From: _____ To: _____ What is the minimum number of hours you will work in one day? _____ What is the maximum number of hours you will work in one day? _____
Type of Work Seeking	
Type of Position(s) Preferred	_____ Home Maker _____ Personal Care _____ Companion _____ Live-In _____ Other: _____ <div style="text-align: center;">(Specify)</div> Live-in care usually requires that you to in a client's home continuously for 3-4 days at a time every week. Indicate which shifts you will accept: _____ Weekdays (Monday a.m. to Friday a.m.) _____ Weekends: (Friday a.m. to Monday a.m.)

<p>Clients Not Willing/Able to Work With</p>	<p> <input type="checkbox"/> Dementias/Alzheimer's <input type="checkbox"/> Physical Disabilities <input type="checkbox"/> Smokers <input type="checkbox"/> Pets <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Females <input type="checkbox"/> Behavioral Disorders <input type="checkbox"/> Males <input type="checkbox"/> Elderly (over 65) <input type="checkbox"/> Client use of marijuana for medicinal purposes <input type="checkbox"/> Children <input type="checkbox"/> HIV Positive/Aids <input type="checkbox"/> Other: _____ <p style="text-align: center;">(Specify)</p> </p>
<p>Duties Not Willing/Able to Perform</p>	<p> <input type="checkbox"/> Bathing <input type="checkbox"/> Housekeeping <input type="checkbox"/> Grooming <input type="checkbox"/> Laundry <input type="checkbox"/> Oral Care <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Dressing <input type="checkbox"/> Shopping <input type="checkbox"/> Bowel Care <input type="checkbox"/> Transportation <input type="checkbox"/> Bladder Care <input type="checkbox"/> Medication Reminding <input type="checkbox"/> Feeding <input type="checkbox"/> Friendly Reassurance Phone Call/Home Visit <input type="checkbox"/> Ambulation <input type="checkbox"/> Other _____ </p>
<p>Experience</p>	<p>Indicate which of the following you have experience in:</p> <p> <input type="checkbox"/> Bathing/Showering <input type="checkbox"/> Housekeeping <input type="checkbox"/> Grooming <input type="checkbox"/> Laundry <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Dressing <input type="checkbox"/> Shopping <input type="checkbox"/> Bowel Care <input type="checkbox"/> Transportation <input type="checkbox"/> Bladder Care <input type="checkbox"/> Medication Reminding <input type="checkbox"/> Feeding <input type="checkbox"/> Friendly Reassurance Phone Call or Home Visit <input type="checkbox"/> Ambulation <input type="checkbox"/> Socialization <input type="checkbox"/> Toileting <input type="checkbox"/> Other _____ <p style="text-align: center;">(Specify)</p> </p>
<p>Assignment Location</p>	<p>Are you restricted in the geographical location you are willing/able to work? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____</p>
<p>Transportation</p>	
<p>Type</p>	<p> <input type="checkbox"/> Private Vehicle <input type="checkbox"/> Bus <input type="checkbox"/> Bike _____ Other: _____ <p style="text-align: center;">(Specify)</p> </p>
<p>Driver's License</p>	<p>Do you have a valid Driver's License?: _____</p>
<p>Transporting Clients</p>	<p> Are you willing to transport clients in your private vehicle? _____ Do you have adequate vehicle insurance? _____ Are you willing to drive a client's vehicle? _____ Are you willing to escort a client in their own vehicle? _____ Are you willing to escort a client on public transportation? _____ Comments: _____ </p>
<p>Abuse Investigation</p>	

	<p>Have you ever been investigated for abuse, neglect or domestic violence? If "yes", explain: ___Yes___No _____ _____ _____</p>
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Reference Information	
Work Related #1 (Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____. Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Work Related #2 (2nd Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____. Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Work Related #3 (3rd Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____. Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Personal #1	Name _____ Address: _____ Telephone No. & Email Address: _____: Nature of Friendship (<i>friend, co-worker, family etc.</i>) _____ (<i>Other than relative.</i>)
Personal #2	Name _____ Address: _____ Telephone No. & Email Address: _____: Nature of Friendship (<i>friend, co-worker, family etc.</i>) _____ (<i>Other than relative.</i>)

I certify that, to the best of my knowledge, the answers given are true and complete and that purposeful misrepresentation may result in rejection of my application. I authorize investigation of all statements contained in this application, as required.

Home Health Care Agency of Arkansas, LLC

Additionally, I authorize former employers, references and any other individual/organizations to provide information to Home Health Care Agency of Arkansas, LLC and I hereby release and discharge any of the above and Home Health Care Agency of Arkansas, LLC from any liability of any kind or nature. I also understand that it is my responsibility to keep such information current and accurate by updating it as often as necessary

I agree to a physical examination, if requested, and understand that failure to meet any medical and/or health requirements for the position may prevent my employment with the Agency. I also understand that employment, for certain positions, may be conditional upon successful completion of a substance abuse screening test and a criminal background check

If further understand that, if hired, I may be required to provide proof that I am a citizen of the United States or proof that I am currently authorized to work in the United States.

Applicant's Signature

Date