



**SUPPORT FOR HOME.**

# APPLICATION FOR EMPLOYMENT: HOME CARE AIDE

Mail application to: Support For Home, 1333 Howe Avenue, Suite 206, Sacramento, CA 95825  
 FAX application to: Support For Home, 916-564-6847  
[www.supportforhome.com](http://www.supportforhome.com) Tel: 916-482-8484 530-792-8484

## PERSONAL INFORMATION

Name (last name, first name)		Social Security No.	
Present Address		City	State Zip
Are you 18 years or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home phone	Cell phone	Email Contact

## DESIRED EMPLOYMENT

Position applied for	Date you can start	Salary desired
Are you employed now? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, may we make an inquiry of your present employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for <input type="checkbox"/> Live-in <input type="checkbox"/> Hourly Number of hours _____
Who referred you to us? _____	Do you have a current driver license? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you own a car, with current insurance in your name? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Are you willing to work</b> <input type="checkbox"/> 2-hour shifts Yes <input type="checkbox"/> No <input type="checkbox"/> 3-hour shifts Yes <input type="checkbox"/> No <input type="checkbox"/> 4-hour shifts Yes <input type="checkbox"/> No <input type="checkbox"/> >4-hour shifts? Yes <input type="checkbox"/> No		
<b>Days and times of the week you can work hourly shifts:</b> Sunday _____ to _____ am/pm Monday _____ to _____ am/pm Tuesday _____ to _____ am/pm Wednesday _____ to _____ am/pm Thursday _____ to _____ am/pm Friday _____ to _____ am/pm Saturday _____ to _____ am/pm		
<b>Are you willing to work several 24-hour shifts in a row?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, days and time that you can start:</b> Sunday _____ am/pm Monday _____ am/pm Tuesday _____ am/pm Wednesday _____ am/pm Thursday _____ am/pm Friday _____ am/pm Saturday _____ am/pm		
<b>Are you willing to work 12-hour overnight shifts?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, earliest start and latest end time:</b> Sun/Mon _____ to _____ pm/am Mon/Tue _____ to _____ pm/am Tue/Wed _____ to _____ pm/am Wed/Thu _____ to _____ pm/am Thu/Fri _____ to _____ pm/am Fri/Sat _____ to _____ pm/am Sat/Sun _____ to _____ pm/am		
<b>Locations willing to travel to or distance from home (Elk Grove, Sacramento, Woodland, Davis, Roseville, etc..., 15miles, 20 miles, 40miles etc... Note: Commute miles above 15 miles each way may be compensated):</b> _____ _____		
<b>Is there anything that would interrupt a scheduled shift:</b> _____ _____		

## HOME/HEALTHCARE LICENSURE/CERTIFICATION/EDUCATION

License Type <input type="checkbox"/> RN <input type="checkbox"/> LVN <input type="checkbox"/> CNA <input type="checkbox"/> HHA	License/Certification No.	State	Expiration Date		
CPR Expiration Date:	Last TB screen Date:				
School Level	Name and Location of School	# Years Attended	Did you Graduate?	Year of Graduation	Subjects Studied
College/Professional					
College/Professional					
Trade, Business Or Correspondence School					



## GENERAL INFORMATION

Please list any other work related information you think would be helpful to us in considering you for employment, such as foreign language, additional work experience, volunteer work, activities, accomplishments, publications etc.

**Languages spoken/written** \_\_\_\_\_

**Special Training** \_\_\_\_\_

**Special Skills** \_\_\_\_\_

## FORMER EMPLOYERS

List your last three employers, starting with the most recent one first.

Name of present or last employer				
Address		City	State	Zip
Starting date	Leaving date		Job title	
Weekly start salary	Weekly end salary		May we contact your supervisor?	Yes No
Name of supervisor		Title	Phone	
Description of work _____				
Reason for leaving _____				

Name of present or last employer				
Address		City	State	Zip
Starting date	Leaving date		Job title	
Weekly start salary	Weekly end salary		May we contact your supervisor?	Yes No
Name of supervisor		Title	Phone	
Description of work _____				
Reason for leaving _____				

Name of present or last employer				
Address		City	State	Zip
Starting date	Leaving date		Job title	
Weekly start salary	Weekly end salary		May we contact your supervisor?	Yes No
Name of supervisor		Title	Phone	
Description of work _____				
Reason for leaving _____				



**PROFESSIONAL REFERENCES**

Below, give the names of three professional references with whom you have worked.

Name	Address	Work Relationship	Phone #	Years known
1				
2				
3				

**PERSONAL REFERENCES**

Below, give the names of three persons you are not related to whom you have known for at least one year.

Name	Address	Relationship	Phone #	Years known
1				
2				
3				

**AUTHORIZATION**

Are you legally authorized to work in the USA?

Yes  No

(Should you become employed by Support For Home, you will be required to provide documentation proving that your eligibility to work in the USA).

Have you ever been convicted of a felony or misdemeanor crime?

Yes  No

Are you currently using or have you in the past used illegal drugs?

Yes  No

(This does not apply if there was a juvenile conviction. A criminal conviction will not necessarily bar you from employment. We will consider the nature of the crime, the time that has expired since the occurrence and any rehabilitation you have undergone).

I authorize Support For Home to obtain any relevant information (including extensive local and national criminal background checks, social security verification credit history and motor vehicle investigations) needed to make an employment decision. I authorize Support For Home to disclose this application along with any information about me obtained through reference checks or during the course of the interview process for state, federal contractual, or accreditation audits purposes. I also authorize Support For Home to disclose any of my performance appraisals, disciplinary records or skills tests for the same purposes as above. I release Support For Home from any individual or entity providing information to Support For Home from all liability for any damages from the disclosure of the information.

I understand and agree that nothing contained in this employment application or in granting an interview creates an employment contract between Support For Home and me for either employment or for the providing of any benefits. No promises regarding employment have been made to me. If I am offered employment, I understand that it is conditional upon a clear criminal background check and that the employment can be terminable "at will", and that I have a right to terminate my employment at any time and that Support For Home also retains a similar right to terminate my employment at any time.

I understand that should I become employed by Support For Home, my work assignments, schedules and work locations are subject to change according to the needs of the business and the clients of Support For Home.

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that if employed, falsified statements on this application shall be considered grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed to you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Pursuant to Title VII of the Civil Rights Act of 1964 (42 U.S.C. Et Seq) and 45 C.F.R. part 80, section 504 of the Rehabilitation Act of 1973, as amended (29 U/S/C. 794) and 45 C.F.R. Part 84, and the Age Discrimination Act of 1975 (42 U/S/C/ 6101 Et Seq) and 45 C.F.R. Part 91, Support For Home adheres to an equal opportunity policy for all persons seeking admission as clients or seeking employment , and for all persons employed by the agency. Support For Home does not discriminate because of age, race, color, religion, military status, marital status, gender preference, sex, national origin or disability.



DISCLOSURE STATEMENT / DRUG TESTING CONSENT

Support for Home conducts a criminal background check on all employees who will provide direct care services to children, developmentally disabled individuals and vulnerable adults. Prior to making this check you are required by law to disclose any convictions you may have had relating to the following.

By signing this document you are attesting that that you have truthfully answered the questions listed below and that you are willing to undergo a drug test.

If you have been convicted, please circle yes or no and discuss it with your interviewer. This information will be kept confidential.

- 1. [yes or no] Convicted of any crime against children or other persons: Aggravated murder, first or second degree murder, first of second degree kidnapping, first, second or third degree assault; first, second or third degree assault of a child; first, second or third degree rape; first, second or third degree rape of a child; first or second degree robbery, first degree arson, first degree burglary; first of second degree manslaughter, first of second degree extortion, indecent liberties, incest; vehicular homicide, first degree promotion of prostitution; communication with a minor, unlawful imprisonment; simple assault; sexual exploitation of a minor; first or second degree criminal mistreatment; child abuse or neglect as defined in state law, first or second degree custodial interference; malicious harassment; first, second or third degree child molestation, first or second sexual misconduct with a minor, patronizing a juvenile prostitute; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault, violation of child abuse restraining order; child buying or selling; prostitution; felony indecent exposure; criminal abandonment; or any of these crimes as they may be renamed in the future.
2. [yes or no] Convicted of crimes relating to financial exploitation if the victim was a vulnerable adult: A conviction for first, second or third degree extortion; first, second or third degree theft; first or second degree robbery, forgery; or any of these crimes that maybe renamed in the future. A vulnerable adult is an adult who lacks the functional, mental or physical ability to care for themselves.
3. [yes or no] Convicted of crimes related to drugs: A conviction of a crime to manufacture, deliver, or possession with intent to manufacture or deliver a controlled substance.
4. [yes or no] Found in any dependency action: to have sexually assaulted or exploited any minor or to have physically abused any minor.
5. [yes or no] Found by a court in a domestic relations proceeding: to have sexually abused or exploited any minor or to have physically abused any minor.
6. [yes or no] Found in any disciplinary board final decision to: have sexually or physically abused or exploited any minor, developmentally disabled person or to have abused or financially exploited any vulnerable adult; any final decision issued by a disciplining authority under chapter 18.130 RCM or the secretary if the department of health for the following business or professions; Chiropractic, Dentistry, Dental Hygiene, Massage, Midwifery, Naturopathy, Osteopathic medicine and surgery, Physical Therapy, Physicians, Practical Nursing, Registered Nursing and Psychology.
7. [yes or no] Found by a court in a protection proceeding under chapter: to have abused or financially exploited a vulnerable adult. The illegal or improper use of a vulnerable adult or that adult's resources for another person's profit or advantage.

All success applicants undergo drug screening. Please list any prescription medications that you are taking which you believe may affect the results of the drug test. Please put 'Not Applicable' if none.

Table with 3 columns: Drug name, Dosage, Frequency. Includes horizontal lines for data entry.

Are you willing to undergo a drug test? Fill in Yes or No: \_\_\_\_\_

Employee signature: \_\_\_\_\_

Date: \_\_\_\_\_

## AIDE SKILLS CHECKLIST

Name \_\_\_\_\_

Date \_\_\_\_\_

**Please check any that apply:**

- Certified Nurse Assistant       Home Health Aide
- CPR       First Aid
- Other \_\_\_\_\_

**Please check only those skills you are currently clinically competent to perform:**

- |   |  |
|---|--|
| <input type="checkbox"/> Complete Bed Bath                    |  |
| <input type="checkbox"/> Assist Patient with Bath/Shower      |  |
| <input type="checkbox"/> Skin Care                            |  |
| <input type="checkbox"/> Back Care                            |  |
| <input type="checkbox"/> Oral Care                            | <input type="checkbox"/> Wound Care                      |
| <input type="checkbox"/> Hair Care                            | <input type="checkbox"/> Assess for changes              |
| <input type="checkbox"/> Shave Patient                        | <input type="checkbox"/> Know signs of Infection         |
| <input type="checkbox"/> Nail Care (No cutting of nails)      | <input type="checkbox"/> Change Non-sterile dressings    |
| <input type="checkbox"/> Turn and Reposition                  |  |
| <input type="checkbox"/> Passive ROM                          | <input type="checkbox"/> Make a bed -Unoccupied/Occupied |
| <input type="checkbox"/> Bedpan – Urinal                      | <input type="checkbox"/> Side Rails                      |
| <input type="checkbox"/> Incontinence Care                    | <input type="checkbox"/> Restraints                      |
| <input type="checkbox"/> Catheter Care-Cleaning, Emptying Bag | <input type="checkbox"/> Transfer Patient                |
| <input type="checkbox"/> Ostomy –Change/Clean Bag             | <input type="checkbox"/> To/From Bed                     |
| <input type="checkbox"/> Support Hose                         | <input type="checkbox"/> To/From Chair/Wheelchair        |
| <input type="checkbox"/> Dressing Patient                     | <input type="checkbox"/> To/From Toilet                  |
|   | <input type="checkbox"/> To/From Bathtub/Shower          |
|   | <input type="checkbox"/> Use of Hoyer Lift               |
|   | <input type="checkbox"/> Lift 25 pounds                  |



## AIDE SKILLS CHECKLIST (Continued)

**Please check patient skills you are currently competent to perform:**

- Assist Patient's Ambulation
  - With Walker
  - With Cane
  - With Crutches
  - Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Assist Patient to do Physical therapy
- Assist Patient to do Speech Therapy
- Assist Patient to do occupational Therapy
- Nutrition – Basic Food Groups-Can Prepare Meals
- Specialty Foods –  Diabetic     Low Fat, Low Cholesterol     Low Salt     Soft, Liquid diet
- Feeding patient – Swallowing Difficulty
- Documenting I&O
- Reporting Client Information to Nursing Supervisor, Family, Physician
- Cooking
- Household Organization
- Light Housekeeping
- Laundry
- Shopping
- Planning Activities for Patients (Within their age group, physical condition and psychological ability)
- Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





## Request For Conviction/Criminal History Record

Signature below authorizes and requests any present or former employer, school, police department, financial institution, division of motor vehicles or other persons or agencies having personal knowledge about me to furnish bearer with any and all information in their possession regarding me, in connection with an application for employment. I give permission that a photocopy of this authorization be accepted with the same authority as the original.

Under the federal Fair Credit Reporting Act (FCRA) and other applicable state law, you have certain rights with regard to consumer reports obtained for employment purposes, including, upon request, disclosure of information on you in the reporting agency's file at the time of the request, including the identification of persons who have procured a consumer report concerning you, and reasonable opportunity to respond to any information in the report is disputed by you. The FCRA, 15 U.S.C. 1681, is designed to promote accuracy, fairness and privacy of information in the files of every "consumer reporting agency" (CRA). You may have additional rights under state law. Request for disclosure of the reporting agency's file should be made in writing within a 60 day time period by certified mail to Background Investigations, Inc., PO Box 3366, Lynnwood, WA 98046-3366. Website address: <http://www.wedobackgroundchecks.com/> You have a right to request of any written report provided to Support For Home, Inc. The undersigned hereby acknowledges that he / she has read or has had read to him / her the above statement and has understood it and agrees to be bound by it.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Date