

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
End Time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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

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 CONTINGENT 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 Employer's Name Date

MONTH / DATE / YEAR

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:

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