

## EMPLOYMENT APPLICATION

### Personal Data

Legal Name (Last)		(First, MI)		Position Applied For:	
Is there any additional information relative to change of name, use of an assumed name, or nickname necessary to permit a background check of your work and education records? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please provide past name(s) and date(s) used, so we may verify employment and education.					
Name	From	To	Name	From	To
<b>Address (List all addresses from past seven (7) years – Use back of form if necessary.</b>					
Current Address - Street		City	State	Zip Code	Years at Address
Previous Address – Street		City	State	Zip Code	Years at Address
Home Telephone No.		Current Work Telephone No.		Cellular Telephone No.	
Email Address:		Can you produce evidence of the right to work while in the U.S.? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Are you at least 18 years of age <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
What type of work are you interested in? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Per Diem		Date you will be available for work?		Have you ever held a position with the company? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, What position?	
Emergency Contact Name:		Relationship:		Contact #: Secondary Contact #:	

### EDUCATION

School Name <i>(City, State Required)</i>	Major/Minor	Graduate	Type of Degree	Grade Point Average
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> GED		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

**EMPLOYMENT** *List all employment during the past 10 years. If you need more space, use additional paper. We may contact your previous employer.*

<b>(1) Employer's Name</b>	Street Address	City	State	Zip Code
Job Title	Supervisor's Name/Title	Supervisor's Telephone No.		Dates of Employment (mm/yy) From: to
Reason for Leaving:				
<b>(2) Employer's Name</b>	Street Address	City	State	Zip Code
Job Title	Supervisor's Name/Title	Supervisor's Telephone No.		Dates of Employment (mm/yy) From: to
Reason for Leaving:				
<b>(3) Employer's Name</b>	Street Address	City	State	Zip Code
Job Title	Supervisor's Name/Title	Supervisor's Telephone No.		Dates of Employment (mm/yy) From: to
Reason for Leaving:				

**U.S. MILITARY (Active Duty including Reserve or National Guard Service)**

Branch of Service	Rank	Type of Discharge	Special Skills of Training Acquired in Service
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**COMPUTER SKILLS**

Typing _____ wpm	List software packages with which you have experience.
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**LANGUAGES**

Language #1	<input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write	Language #2	<input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write	Language #3	<input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write
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**BUSINESS REFERENCES**

Name	Job Title	Address	Telephone No.

**PLEASE INDICATE YOUR SCHEDULE AVAILABILITY, TRAVEL AVAILABILITY AND SKILLS**

Please check DAYS available	<input type="checkbox"/> Sun	<input type="checkbox"/> Mon	<input type="checkbox"/> Tue	<input type="checkbox"/> Wed	<input type="checkbox"/> Thu	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat	Comments;	
Please check SHIFTS available	<input type="checkbox"/> Days	<input type="checkbox"/> Eve	<input type="checkbox"/> Night	<input type="checkbox"/> Live-In	<input type="checkbox"/> 1-2 hours	<input type="checkbox"/> 2-4 hours	<input type="checkbox"/> 4-8 hrs.	<input type="checkbox"/> 8-12 hrs.	Other:
Number of WEEKENDS available to work per month				Which holidays you are available to work				<input type="checkbox"/> New Year <input type="checkbox"/> Memorial Day <input type="checkbox"/> Independence Day <input type="checkbox"/> Labor Day <input type="checkbox"/> Thanksgiving <input type="checkbox"/> Christmas	
How many MILES are you willing to drive to and from work?						Comments:			

**CLIENTS YOU ARE NOT WILLING/ABLE TO WORK WITH**

<input type="checkbox"/> Dementias/Alzheimer's	<input type="checkbox"/> Smokers
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Pets (Specify): <input type="checkbox"/> Cats <input type="checkbox"/> Dogs <input type="checkbox"/> Other: _____
<input type="checkbox"/> Behavioral Disorders	<input type="checkbox"/> Females
<input type="checkbox"/> Elderly (over 65)	<input type="checkbox"/> Males
<input type="checkbox"/> HIV Positive/AIDS	<input type="checkbox"/> Client use of medically prescribed marijuana
<input type="checkbox"/> Other (Specify): _____	

**TRANSPORTATION**

What type of transportation do you use?	<input type="checkbox"/> Car <input type="checkbox"/> Bus <input type="checkbox"/> Bike <input type="checkbox"/> Other: _____
Do you have a valid Driver License: <input type="checkbox"/> Yes <input type="checkbox"/> No	DL #: _____ Expiry Date: _____
Are you willing to transport clients in your private vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have vehicle insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you willing to drive a client's vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you willing to escort a client in their own vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you willing to escort a client on public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No

**ABUSE INVESTIGATION**

Have you ever been investigated for abuse, neglect, or domestic violence? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, explain:
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**AUTHORIZATION AND UNDERSTANDING****RELEASE OF PRIOR PERSONNEL INFORMATION**

By signing this application, I agree that all of the information now or later given by me in support of my application for employment is true and complete. I understand that you may verify any of the information concerning my employment, education, credit, or medical history with the appropriate individuals, organizations, or governmental agencies. I give these individuals, organizations or governmental agencies my permission to release any information that you need, including my previous disciplinary record, without requiring them to contact me or give me a written notice before revealing the information to you. I understand that no verification of my credit history or request for a 'consumer report' under the Fair Credit Reporting Act may be undertaken by you without my express written authorization in a separate document. By signing this application, and in the case of a consumer report under the Fair Credit Reporting Act, should I sign the separate Authorization for credit reports on my own, I release you and them from any liability whatsoever arising out of an information request or disclosure. I agree that any false information in support of my application may subject me to discharge at any time during my employment.

**AT-WILL EMPLOYMENT STATUS**

**I AGREE THAT EITHER PARTY MAY TERMINATE THE EMPLOYMENT RELATIONSHIP, WITH OR WITHOUT CAUSE, AT ANY TIME, FOR ANY REASON, AND I FURTHER AGREE THAT THIS AGREEMENT MAY ONLY BE CHANGED BY THE PRESIDENT OF THE COMPANY, IN WRITING, DIRECTED TO ME PERSONALLY, AND SIGNED BY THE PRESIDENT.** I agree that I shall be bound by the other rules, regulations, and terms and conditions of employment of the company as they are from time to time changed and that no additional obligations can be imposed by me on the company except those which have been acknowledged, in writing, by the company president or his/her designated representative. I further agree that my employment is conditional upon satisfactory completion of documentation as required by the Immigration Reform and Control Act of 1986 and until such time as the result of my pre-employment physical (if such physical is required) are known.

**RELEASE FOR REFERENCE CHECKS**

I authorize the Company to contact my previous employers for work-related references.

**RELEASE FOR BACKGROUND SCREENING**

I authorize the Company to verify any information that I provide in connection with my employment. I release the Company and its authorized representatives of all liability resulting from the use of background information about me for employment purposes.

X \_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

## Skill Assessment

Please check all that apply

- Lifting, positioning
- Skin Care, apply lotion
- Light massage if client allow
- Light Cooking
  - Meal Preparation
  - Light House Keeping
  - Kitchen Light Cleaning
  - Garbage Collection
- Use of Medical Equipment
  - 1) Hoyer Lift
  - 2) Hospital Bed
  - 3) Wheelchair
  - 4) Oxygen turning on and off
  - 5) Front wheel walker / gait belt
- Incontinent Management
  - 1) Change diapers
  - 2) Peri- Care
  - 3) Change linen and chux
- Able to empty Foley bag
- Bed Making
- Able to communicate with client
  - 1) Speak English
  - 2) Secondary Language
- Flexibility hours
- Preferred hours/ days
- Open to work in Residential Care

# CRIMINAL RECORD STATEMENT

State law requires that persons associated with licensed facilities or Home Care Aide Registry applicants be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.

**Have you ever been convicted of a crime in California ?** .....  YES  NO

You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.

**Have you ever been convicted of a crime from another state, federal court, military or jurisdiction outside of U.S.?** .....  YES  NO

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

If you answer YES, give details on the back of this page indicating the nature and circumstances of each crime and the date and the location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You had no jail time or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside or the sentence was suspended.

**NOTE:** IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) WILL RESULT IN AN EXEMPTION DENIAL, LICENSE APPLICATION DENIAL, LICENSE REVOCATION, OR EXCLUSION FROM A LICENSED FACILITY/ORGANIZATION.

<b>I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.</b>			
FACILITY/ORGANIZATION NAME FIRST PROMISE CARE SERVICES		FACILITY/ORGANIZATION NUMBER 374700054	
YOUR NAME (PRINT CLEARLY)	YOUR ADDRESS	CITY	ZIP
SOCIAL SECURITY NUMBER (SEE PRIVACY STATEMENT ON REVERSE SIDE)	DATE OF BIRTH	DMV LICENSE NUMBER	
SIGNATURE		DATE	

**I. Instructions to Respondents:**

If you have been convicted of a crime in California, another state or in federal court, provide the following information:

*(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.)*

What was the offense? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In which state and city did you commit the offense? \_\_\_\_\_

\_\_\_\_\_

When did this occur? \_\_\_\_\_

\_\_\_\_\_

Tell us what happened. (Use additional sheets of paper if needed) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

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

**II. Instructions to Licensees:**

If the person discloses a criminal conviction, review the person’s statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility/organization personnel file and send a copy to your LPA.

**PRIVACY STATEMENT**

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person’s SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, 1596.871, and 1796.19). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

**NOTE: IMPORTANT INFORMATION**

The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask, the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

## STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

*NOTE: RETAIN IN EMPLOYEE/ VOLUNTEER FILE*

NAME

POSITION

Home Care Aide

FACILITY

FIRST PROMISE CARE SERVICES

California law **REQUIRES** certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a "mandated reporter."

### PERSONS WHO ARE REQUIRED TO REPORT ABUSE

**Mandated reporters** include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility (Welfare and Institutions Code (WIC) Section 15630(a)). **Care custodian** means an administrator or an employee of most public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff (WIC Section 15610.17).

### PERSONS WHO ARE THE SUBJECT OF THE REPORT

**Elder** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age and those admitted as inpatients in 24-hour health facilities (WIC Section 15610.23).

### REPORTING RESPONSIBILITIES AND TIME FRAMES

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect occurred, shall complete form SOC 341, "Report of Suspected Dependent Adult/Elder Abuse" for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury (as defined in WIC Section 15610.67), report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, and was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.

- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:
  - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
  - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.
- For all other abuse, mandated reporters shall report by telephone or through a confidential internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

## PENALTY FOR FAILURE TO REPORT ABUSE

Failure to report abuse of an elder or dependent adult is a MISDEMEANOR CRIME, punishable by jail time, fine or both (WIC Section 15630(h)). The reporting duties are individual, and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report (WIC Section 15630(f)).

## CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order. Any violation of confidentiality is a misdemeanor punishable by jail time, fine, or both (WIC Section 15633(a)).

## DEFINITIONS OF ABUSE

**Physical abuse** means any of the following: (a) Assault, as defined in Section 240 of the Penal Code; (b) Battery, as defined in Section 242 of the Penal Code; (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code; (d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water; (e) Sexual assault, that means any of the following: (1) Sexual battery, as defined in Section 243.4 of the Penal Code; (2) Rape, as defined in Section 261 of the Penal Code; (3) Rape in concert, as described in Section 264.1 of the Penal Code; (4) Spousal rape, as defined in Section 262 of the Penal Code; (5) Incest, as defined in Section 285 of the Penal Code; (6) Sodomy, as defined in Section 286 of the Penal Code; (7) Oral copulation, as defined in Section 288a of the Penal Code; (8) Sexual penetration, as defined in Section 289 of the Penal Code; or (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code; or (f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions: (1) For punishment; (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given; or (3) For any purpose not authorized by the physician and surgeon (WIC Section 15610.63).

**Serious bodily injury** means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

**Neglect** (a) means either of the following: (1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or (2) The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise. (b) Neglect includes, but is not limited to, all of the following: (1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; (2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment; (3) Failure to protect from health and safety hazards; (4) Failure to prevent malnutrition or dehydration; or (5) Failure of an elder or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health (WIC Section 15610.57).

**Financial abuse** of an elder or dependent adult occurs when a person or entity does any of the following: (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; (2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; or (3) Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 15610.70 (WIC Section 15610.30(a)).



**Abandonment** means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody (WIC Section 15610.05).

**Isolation** means any of the following: (1) Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls; (2) Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons; (3) False imprisonment, as defined in Section 236 of the Penal Code; or (4) Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors (WIC Section 15610.43).

**Abduction** means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, as well as the removal from this state or the restraint from returning to this state, of any conservatee without the consent of the conservator or the court (WIC Section 15610.06).

AS AN EMPLOYEE OR VOLUNTEER OF THIS FACILITY, YOU MUST COMPLY WITH THE DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS, AS STATED ABOVE. IF YOU DO NOT COMPLY, YOU MAY BE SUBJECT TO CRIMINAL PENALTY. IF YOU ARE A LONG-TERM CARE OMBUDSMAN, YOU MUST COMPLY WITH FEDERAL AND STATE LAWS, WHICH PROHIBIT YOU FROM DISCLOSING THE IDENTITIES OF LONG-TERM RESIDENTS AND COMPLAINANTS TO ANYONE UNLESS CONSENT TO DISCLOSE IS PROVIDED BY THE RESIDENT OR COMPLAINANT OR DISCLOSURE IS REQUIRED BY COURT ORDER (Title 42 United States Code Section 3058g(d)(2); WIC Section 9725).

I, \_\_\_\_\_, have read and understand my responsibility to report known or suspected abuse of dependent adults or elders. I will comply with the reporting requirements.

SIGNATURE	DATE
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