

Help At Home, Inc.

4535 Missouri Flat Rd. Ste. 2-H, Placerville, CA 95667

Phone (530) 622.9020 Fax (530) 622.4055

13405 Folsom Blvd., Ste. 512, Folsom, CA 95630

Phone (916) 933.9050 Fax (916) 985.6095

To All Applicants:

Thank you for your interest in **Help At Home, Inc.** Please read this entire application very carefully. It is imperative that you provide *complete* and *accurate* information.

At **Help At Home, Inc.**, it is our goal to provide high-quality assistance to older adults or those with physical or mental limitations. Our services cover all of Sacramento, Placer, and El Dorado counties. As a potential service provider, it will be your job to ensure that our clients are your number one priority. It is our agency's goal to make the best match possible between the client and the assistance provider. We are committed to reaching not only those who need help but may not realize assistance is an affordable possibility.

In order to achieve our goal, we need to maintain an accurate and current personnel file. This is the primary tool we use for ensuring that the caregivers we refer are indeed qualified, insured and healthy! Most importantly, all information is useful as we search for the perfect match between care provider and client.

Our application package includes:

Application

- Complete all pages. **If incomplete, the application will be returned to you.**
- To process your application, you must provide us with complete:
 - Reference Names and Employment Names
 - Street Numbers and Street Names
 - City, State, and Zip Code for each
- If you choose not to answer a question, you may write "no answer"

Reference Letter (only signature and date required)

Skills Checklist

Notification and Authorization to Obtain Information form

Please note that our agency checks employment and personal references and performs a **criminal background check on all applicants.**

TO COMPLETE THE PROCESS, YOU MUST PROVIDE THE FOLLOWING:

- **Current** Driver's License (clear photocopy)
- Social Security Card (clear photocopy)
- Proof of Auto Insurance – **Current** Liability Coverage (clear photocopy)
- TB test results or Chest X-ray results – performed within the last year
- Photocopy of C.N.A. and/or H.H.A. Certificate (even if expired)

By signing below, I confirm that I have read and completely understand the above application information.

Applicant

Date

Help At Home, Inc.

13405 Folsom Blvd., Ste. 512

Folsom, CA 95630

P (916) 933-9050 F (530) 622-4055

Employment Application

“An Equal Opportunity Employer”

Hire date	1 st Day of work	Termination date
Interviewer	Interview date / time	Rate

All information must be filled out completely for your application to be considered.

Name Date

Home telephone Cell Phone SS#.....

Email Other phone contact

Do you have an answering machine? Yes No How did you hear about Help At Home?

Current Address

.....
No. Street City State Zip

Mailing Address, if different from current address:

.....
No. Street City State Zip

In case of emergency, contact

Name Phone

Address City, State, Zip

Doctor Phone

Employment Desired

If hired, on what date can you start work?

Are you applying for: Regular full-time work? Yes No

Regular Part-time work? Yes No

Are you available for: 24-hour shifts? Yes No

Work on weekends? Yes No

Give a brief description of your availability:

Mon Tue Wed Thu Fri Sat Sun Day hours

Mon Tue Wed Thu Fri Sat Sun Overnights Night hours

Placement Preference. Check only the areas in which you are able to provide care.

- Homemaker Companion Shopping / Appointments Personal Care Hospice Care

Indicate YES by checking all items which apply to you

- Do you speak a second language? If yes, describe
- Do you have a driver's license? DL # Is your car available for jobs? Yes No
- Do you smoke? Yes No CPR? Expiration date
- Allergic to Smoke? Yes No First Aid? Expiration date
- Available to work in home where smoking occurs? Yes No C.N.A. certified? Expiration date
- Allergic to pets? Yes No H.H.A. certified? Expiration date

Districts where you will work

- Cameron Park Diamond Springs Georgetown Orangevale Rescue
- Camino El Dorado Greenwood Pilot Hill Sacramento
- Carmichael El Dorado Hills Grizzly Flats Placerville Shingle Springs
- Citrus Heights Elk Grove Lotus Pollock Pines Somerset
- Coloma Folsom Mt. Aukum Rancho Cordova
- Cool Garden Valley

Personal Information

Have you ever applied to or worked for Help At Home before: Yes No If yes, when

Any friends or relatives working for Help At Home? Yes No

If yes, state name(s) and relationship

If hired, would you have a reliable means of transportation to and from work: Yes No

Are you at least 18 years old? Yes No (If under 18, hire is subject to verification that you are of minimum legal age.)

If hired, can you present evidence of your U.S. citizenship or proof of your legal right to live and work in this country?

Yes No

Are you able to perform the essential function of the job for which you are applying? (Some examples: Meal prep, light housekeeping, assist w/daily activities, personal care, dressing, laundry, change linens, accompany on errands/appointments, etc.) Yes No If no, describe the functions that cannot be performed

Have you ever been convicted of a criminal offense (felony or serious misdemeanor)? Yes No If yes, state the nature of the crime(s), when and where convicted and disposition of the case(s)

.....
.....

(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.)

Personal References

Names and addresses must be complete for your application to be considered

1. Name			Telephone (_____)
Street No.	Street Name		How long have you known? From _____ To _____
City	State	Zip	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why?

2. Name			Telephone (_____)
Street No.	Street		How long have you known? From _____ To _____
City	State	Zip	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why?

3. Name			Telephone (_____)
Street No.	Street Name		How long have you known? From _____ To _____
City	State	Zip	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why?

4. Name			Telephone (_____)
Street No.	Street Name		How long have you known? From _____ To _____
City	State	Zip	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why?

5. Name			Telephone (_____)
Street No.	Street Name		How long have you known? From _____ To _____
City	State	Zip	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why?

6. Name			Telephone (_____)
Street No.	Street Name		How long have you known? From _____ To _____
City	State	Zip	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why?

Health Questionnaire

Name

Date of last physical check-up _____ - _____ - _____

Date of last TB test or chest x-ray _____ - _____ - _____ Results: Positive Negative

Have you consulted or been treated by a physician for a serious illness in the past five years? Yes No

If yes, please describe and explain the work limitations

.....

Do you have any physical, medical or mental disabilities or handicaps that would prevent you from performing the type of work you applied for? Yes No

If yes, please explain

.....

Do you take any prescribed medication? Yes No If yes, please explain

.....

Do you have any special medical conditions?

Major operations(s) or illness

.....

Do you have or have you ever been told you have: (check if "yes")

Back disorder or injury	Epilepsy or convulsions	Low blood pressure
Chest pains or pressure	Fainting or dizziness	Menstrual problems
Chronic cough or cold	Frequent headaches	Nervous or mental disorder
Diabetes	Heart disease	Rheumatic fever or arthritis
Dietary restrictions	Hernia	Skin disease
Difficulty hearing/hearing aid	High blood pressure	Varicose veins
Difficulty seeing/glasses/co		

Do you carry health insurance? Yes No If yes, name of insurance company

Please read carefully. Initial each paragraph and Sign below.

_____ I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

_____ I hereby authorize Help At Home Inc. to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the references I have listed to disclose to Help At Home Inc. any and all letters, reports and other information related to my work records, without giving me prior notice of such disclosure. In addition, I hereby release Help At Home Inc, my former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure.

_____ I hereby agree to submit to binding arbitration all disputes and claims arising out of the submission of this application. I further agree, in the event that I am hired by Help At Home Inc, that all disputes that cannot be resolved in informal internal resolution which might arise out of my employment with Help At Home Inc, whether during or after that employment, will be submitted to binding arbitration. I agree that such arbitration shall be conducted under the rules of the American Arbitration Association. This application contains the entire agreement between the parties with regard to dispute resolution, and there are no other agreements as to dispute resolution, either oral or written.

_____ I understand that nothing contained in the application, or conveyed during any interview which may be granted or during my employment, if hired, is intended to create an employment contract between me and Help At Home Inc. In addition, I understand and agree that if I am employed, my employment is for no definite or determinable period and may be terminated at any time, with or without prior notice, at the option of either myself or Help At Home Inc, and that no promises or representations contrary to the foregoing are binding on Help At Home Inc unless made in writing and signed by me and Help At Home Inc designated representative.

_____ I understand that if a Help At Home Inc employee should go to work directly for a Help At Home Inc client or should refer a Help At Home Inc client to another agency and continue on the same client case, the employee will lose all benefits, lose prospective employment options and be legally liable for any loss to Help At Home Inc.

Applicant's Name (Print) _____ Date _____

Applicant's Signature _____

NAME _____

DATE _____

SKILLS CHECKLIST **Check all skills that apply to you:**

Personal Care

- | | | |
|---|--|--|
| <input type="checkbox"/> Adult Diaper change/
Incontinent Care | <input type="checkbox"/> Feeding Tube (G-Tube) | <input type="checkbox"/> Shower |
| <input type="checkbox"/> Bed Bath | <input type="checkbox"/> Make Hospital Bed | <input type="checkbox"/> Skin Care/Massage |
| <input type="checkbox"/> Bed Pan | <input type="checkbox"/> Meds: Assist/Remind | <input type="checkbox"/> Suppositories |
| <input type="checkbox"/> Colostomy Bag/Assistance | <input type="checkbox"/> Mouth Care | <input type="checkbox"/> Toileting Assistance |
| <input type="checkbox"/> Catheter | <input type="checkbox"/> Denture Care | <input type="checkbox"/> Turning/Repositioning |
| <input type="checkbox"/> Condom Catheter application | <input type="checkbox"/> Oxygen | <input type="checkbox"/> Universal Precautions |
| <input type="checkbox"/> Foley Catheter (empty only) | <input type="checkbox"/> Prescribed Exercises | <input type="checkbox"/> Vitals |
| <input type="checkbox"/> Portable Catheter | <input type="checkbox"/> Respite Care | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Foot care/soak/massage | <input type="checkbox"/> Shampoo (in bed) | <input type="checkbox"/> Pulse |
| | <input type="checkbox"/> Shaving (men) | <input type="checkbox"/> Temperature |
| | | <input type="checkbox"/> Injections |

Mobility

- | | | |
|--|---|---|
| <input type="checkbox"/> Fall Risk Supervision | <input type="checkbox"/> Transfers | <input type="checkbox"/> Walking w/cane |
| <input type="checkbox"/> Hands on | <input type="checkbox"/> Wheelchair/Chair | <input type="checkbox"/> Walking w/walker |
| <input type="checkbox"/> Hands off | <input type="checkbox"/> 2-person | |
| <input type="checkbox"/> Gait Belt | <input type="checkbox"/> Partial weight-bearing | |
| <input type="checkbox"/> Hoyer Life Transfer | <input type="checkbox"/> Full weight-bearing | |
| <input type="checkbox"/> Range of Motion Exercises | <input type="checkbox"/> Slide Board | |

Mobility Assistance

- | | | | | |
|---|----------------------------------|---|---------------------------------|-------------------------------------|
| <input type="checkbox"/> Bedside care | <input type="checkbox"/> Commode | <input type="checkbox"/> Shower Seat | <input type="checkbox"/> Walker | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Transfer In/Out of vehicle | | <input type="checkbox"/> Placing wheelchair/walker in vehicle | | |

Homemaking

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Bed linen changes | <input type="checkbox"/> Light housekeeping | <input type="checkbox"/> Clean kitchen | <input type="checkbox"/> Vacuum & Dust |
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Heavy housekeeping | <input type="checkbox"/> Clean bathroom | <input type="checkbox"/> Pet Care |

Transportation

- | | | |
|----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Outings | <input type="checkbox"/> Errands/Shopping | <input type="checkbox"/> Appointments |
|----------------------------------|---|---------------------------------------|

I have Experience in the following care situations:

- Alzheimer's/Dementia – Confusion, Short-term memory loss, Combativeness, Agitation
- Cancer
- Diabetes – Client-managed injections, Glucose monitoring (How?)
- Epilepsy
- Hearing impairment
- Hospice – Comfort care, Cancer, Terminal illness
- Lung Disease – O₂, Emphysema
- Mental Illness
- Multiple Sclerosis
- Paraplegic/Quadriplegic
- Parkinson's – Speech problems, shuffling
- Strokes – Aphasia, generalized weakness, paralysis
- Visual impairment

Nutrition

Can you cook? No Yes If yes: Balanced Diet Veggie Diet Diabetic Diet Salt-Free Diet

Types of food you can cook: _____

For a nutritious **Lunch**, what would you prepare: _____

For a nutritious **Dinner**, what would you prepare: _____