Care Placement Home Health Agency, Inc.

Application for Placement

PLEASE PRINT AND COMPLETE ALL PAGES OF THIS PLACEMENT APPLICATION IN ITS ENTIRETY.
Equal access to programs, services, placement, and employment is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of Care Placement Home Health Agency, Inc.

Position(s) applied for _____ Date of Application _____

Name _____
Last First Middle

Address _____
Street City State Zip Code

( )_____ ( )_____
Telephone# Cellular/Beeper #

_____ _____
Social Security Number E-Mail

Have you ever been placed by this company before? ☐ Yes ☐ No

If yes, Start Date _____ End Date _____ Position held _____

Are you legally eligible for employment in this country? ☐ Yes ☐ No

Are you 21 Year of age or older? ☐ Yes ☐ No

Do you have a current state professional license/certification without restrictions? ☐ Yes ☐ No

If restrictions please explain _____

Have you ever been known by any other name? ☐ Yes ☐ No

If yes please explain _____

Have you ever been convicted of a crime in the last seven (7) years? ☐ Yes ☐ No

If yes please explain _____

CONVICTIONS WILL NOT NECESSARILY BE A BAR TO EMPLOYMENT.

How were you referred to this company? ☐ Agency ☐ Advertising ☐ Employee ☐ Other

If referred by employee list employee's name _____

Do you have any relatives placed by this company? ☐ Yes ☐ No

If yes please list name and relationship _____

Date available for work _____

Schedule ☐ Full time ☐ Part time

Shift desired ☐ Days ☐ Afternoons ☐ Nights ☐ 12 hour

Will you work for flat rate ( ) ☐ yes 24 hours ( ) ☐ yes 12 hour night shift ( ) ☐ no only hourly rate

EMPLOYMENT HISTORY

Provide the following information for your past three employers, assignments, starting with the most recent

Employer		
Address		
Telephone		Office Manager/supervisor
From	To	Position
May we contact this employer?		
Reason you left that position		

Employer		
Address		
Telephone		Office Manager/supervisor
From	To	Position
Reason you left that position		

Employer		
Address		
Telephone		Office Manager/supervisor
From	To	Position
Reason you left that position		

Please describe your work experience:

Any additional comments:

EDUCATION				
SCHOOL NAME AND LOCATION	COURSE OF STUDY	DID YOU GRADUATE	NO OF YRS/CEDITS COMPLETED	DEGREE REC'D
HIGH SCHOOL				
COLLEGE				
TRADE SCHOOL				
OTHER				

PLEASE INDICATE ANY PROFESSIONAL, TRADE, OFFICE, TECHNICAL OR OTHER SKILLS AND ABILITIES POSSESSED BY YOU (I.E., TYPING, PERSONAL COMPUTERS, OFFICE MACHINES, BOOKKEEPING, ETC.)

SKILL/ABILITY	LENGTH AND KIND OF TRAINING	YEARS OF EXPERIENCE

APPLICATION AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

This release and authorization acknowledges that this company may now or at any time while you are under contract, conduct a verification of your education, previous employment/work history, contact personal references, require that you provide a urine specimen, or blood specimen to be tested for the presence of drugs or alcohol and receive any criminal history record information pertaining to you that may be in the files of any federal, state, county, or local criminal justice agency and/or other information as deemed necessary to fulfill job requirements. The results of this verification process will be used to determine eligibility under this company's placement policies. I authorize Care Placement Home Health Agency, Inc. and any of its agents/designated company personnel, to disclose orally and in writing the results of the verification process. The information obtained will not be provided to any other parties other than to the designated authorized representatives of this company. All results will be kept CONFIDENTIAL.

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of placement is true and complete to the best of my knowledge. I understand that if I am placed, any false statement will be considered as cause for possible dismissal.

Signature of applicant _____ Date _____

DO NOT SIGN THE FOLLOWING STATEMENT WITHOUT READING IT CAREFULLY

I, _____ understand that I am working Per Diem for Care Placement Home Health Agency, Inc. I agree to comply with the policies and procedures of Care Placement Home Health Agency, Inc. I understand that my contract and compensation are at will and can be terminated with or without cause or notice, at any time at the option of either Care Placement Home Health Agency, Inc. or myself.

Signature of applicant _____ Date _____

Witness of signature _____ Date _____

CARE PLACEMENT HOME HEALTH AGENCY, INC.

CONFIDENTIAL

Employment Reference Form

FAX: 727-785-7455

Date: _____

Applicant's Name: _____

Position Held: _____

Employment Dates: From _____ To _____

I authorize persons, schools, current and former employers and other organizations and agencies to provide Care Placement Home Health Agency, Inc. any information that is requested, and I hereby release all the persons and agencies providing information from any and all claims and damages with their release of information.

_____

Applicant's Signature

Employer/Former Employer: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

TO BE COMPLETED BY REFERENCE OR CARE PLACEMENT HOME HEALTH AGENCY

The person listed above has applied to Care Placement Home Health Agency, Inc. for placement in the healthcare field and has submitted your name as a professional reference. Please be assured that any response will be kept in the strictest confidence and thank you in advance for this courtesy.

Is the above information correct? ( ) Yes ( ) No

If no, please explain: _____

Applicant left because? _____

Would you rehire? ( ) Yes ( ) No

	Excellent	Good	Fair	Poor
Initiative				
Relates to patients				
Dependability				
Quality of work				
Appearance				
Job knowledge				

Comments: _____

Signature _____ Title: _____

Information acquired via Fax _____ Phone _____ Mail _____

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

2727 Mahan Drive, MS#40
Tallahassee, Florida 32308

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

1-789 (08-11-2010)

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

Care Placement Home Health Agency

C.N.A. / H.H.A. REQUIREMENTS

Applicant name _____Date _____

Please be prepared to provide these items/answer these questions when interviewed:

Y or N Current CNA license or HHA certificate

Y or N Current CPR card (On line courses are not acceptable)

Y or N Current Driver's License and proof of auto insurance

Y or N Social Security Card and Resident Alien Card, if applicable

Y or N Home Health experience

Y or N Have or able to pass a Level II background screening

Y or N Since your last screening/rescreening date, have you had a lapse of employment in health care of more than 90 days?

Y or N Assistance with Self-Administered Medications Certificate (no expiration) 2 hours

Proof of In-Service Training
(C.N.A./H.H.A. are required to have the following training. These courses may be taken after you begin working for us if you do not currently have them)

Y or N Blood Borne Pathogens, Infection Control, HIV/AIDS (no expiration)

Y or N Communication with cognitively impaired/Alzheimer's clients (every 2 years) 2 hours

Y or N Domestic Violence (every 2 years)

Y or N Medical Record Documentation (every 2 years)

Y or N Resident Rights (every 2 years)

Y or N Medical Error Prevention and Safety (every 2 years)

CARE PLACEMENT
Home Health Agency
Caring is Our Business

727-787-8677 / 813-884-6100
Scheduling@RMFHomeCare.com

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