



WELCOME

HomeCare

APPLICATION FOR EMPLOYMENT

Date: _____ HCA Registration Number: _____

Full Name: _____ DOB: _____

Address: _____

E-Mail: _____ Cell#: _____

Vehicle Make/Model/ Year: _____

Is it Insured? _____

Do you have a valid driver's license? _____

DL#: _____

Do you have any allergies? PETS SMOKE NUTS Others: _____

Do you work currently? _____

How soon can you start? _____

Salary Expectations: _____ per hour Last pay rate: _____

DAY/TIME AND AREA OF AVAILABILITY

Desired Shifts: 4hr shifts _____ 8hr shifts _____ 12hr shifts _____ day/night 24hr/live in _____

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
am							
pm							

What area do you live in? _____

Areas you are willing to work on a client with (check all that apply):

- Vacaville El Macero Vallejo Sonoma Rohnert Park
 Dixon Fairfield American Canyon Santa Rosa Petaluma
 Marin Suisun City Napa Benicia Novato

Others: _____

EDUCATION, EXPERIENCE, AND SKILLS

Highest Level of Education

School/College/University: _____

Address: _____

Year Graduated: _____

Special Training, Classes, or Licenses:

Willing to work with (Check all that apply) :

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Women | <input type="checkbox"/> Men | <input type="checkbox"/> Elderly | <input type="checkbox"/> MS |
| <input type="checkbox"/> Companionship | <input type="checkbox"/> Cooking | <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Run errands |
| <input type="checkbox"/> Drive client | <input type="checkbox"/> Lifting/Transfer | <input type="checkbox"/> Gait Belt | <input type="checkbox"/> Hoyer lift |
| <input type="checkbox"/> Terminally ill | <input type="checkbox"/> Hospice Care | <input type="checkbox"/> Dementia | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Infection Prec. | <input type="checkbox"/> Help w/ Exercise | <input type="checkbox"/> Feeding | <input type="checkbox"/> Bathing |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Diabetic Patients | <input type="checkbox"/> Stroke Client | <input type="checkbox"/> Pet Care |
| <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Diabetic Patients | <input type="checkbox"/> Meal Prep | <input type="checkbox"/> C Dif |
| <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Bowel/Bladder Assistance | | |

CONTACTS

References: _____

Emergency Contacts: _____

By signing below, authorization is given to release any and all information necessary for verification of all claims and statements made herewith.

I attest that the information submitted in this application is true and correct to the best of my knowledge and I further understand that any false statement may result in denial or revocation of this certificate.

Print Name and Signature

Date

PERSONNEL RECORD

(Form to be Completed by employee at the time of hire)

FOR HOME CARE ORGANIZATION USE ONLY	
NAME OF HOME CARE ORGANIZATION	
HOME CARE ORGANIZATION ADDRESS	
HOME CARE ORGANIZATION NUMBER	
DATE OF EMPLOYMENT	
DATE OF SEPARATION	

PERSONAL

NAME (LAST FIRST MIDDLE)	AREA CODE/TELEPHONE ()
ADDRESS	DATE OF BIRTH
SOCIAL SECURITY NUMBER: (VOLUNTARY FOR ID ONLY)	DATE OF LAST TB TEST RESULTS OF LAST TB TEST
HAVE YOU EVER BEEN EMPLOYED UNDER A DIFFERENT NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST ALL NAMES USED.
DO YOU POSSESS A VALID CALIFORNIA DRIVER'S LICENSE? <input type="checkbox"/> YES <input type="checkbox"/> NO	CDL NUMBER: _____

POSITION INFORMATION

TITLE OF POSITION	TIME BASE
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EMPLOYMENT

(List most recent experience first. If additional space is needed, please attach a separate page.)

NAME AND ADDRESS OF EMPLOYER	AREA CODE/ TELEPHONE	JOB TITLE AND TYPE OF WORK	REASON FOR LEAVING	DATES	
				FROM	TO
	()				
	()				
	()				
	()				
	()				

Notes:

I hereby certify under penalty of perjury that I am 18 years of age or older and that the above statements are true and correct.
 I give my permission for any necessary verification.

EMPLOYEE SIGNATURE	DATE
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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.

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.			
FACILITY/ORGANIZATION NAME		FACILITY/ORGANIZATION NUMBER	
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.