SPRINGWOOD HEALTH & SUPPORTIVE LIVING SERVICES

1. **What Position are You Applying For?**		2. **What Location or City?**	
4. Last Name		5. First Name	6. Middle Name
7. Mailing Address			8. Day Phone Number ( )
9. City	10. State	11. Zip Code	8a. Alternate Phone Number ( )

LEGAL/INCIDENT HISTORY

12. **Have you ever been convicted of a Felony?** ____ **Yes** ____ **No**
Have you ever been convicted of a Misdemeanor? ____ ***Yes*** ____ ***No***

13. Charge:	14. State and County	15. Date

16. Has DIDD/APS/DHS/DBHDD/APS/DHS/DBHDD ever substantiated an allegation of abuse, neglect or exploitation against you? Yes ☐ No If yes, describe the offense.
☐

____

____

____

17. Do you have any friends or relatives currently working for Springwood Health? ☐ Yes ☐ No
If yes, please name the employee or relative:

EDUCATION

Mark Highest Level Completed: ☐ Some High School ☐ HSD/GED ☐ Associates ☐ Bachelor ☐ Master ☐ Doctorate

Type of Institution	Name of Institution	Dates Attended	Degree Earned	Major
High School				
Training Institute				
College (Undergraduate)				
College (Graduate)				

LICENSURE/CERTIFICATIONS

SPRINGWOOD HEALTH & SUPPORTIVE LIVING SERVICES

Driver License#: ____________________________ Class: _________ Expiration Date: ___/____/______
CPR/First Aid: ____Yes _____No If yes, expiration date ___/___/_____ (Copy must be attached)
List Other Certifications: ____
Typing: _______WPM Computer Knowledge: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

EMPLOYMENT HISTORY
Please provide 5 years of employment history
(List Most Recent Employment First)

MOST RECENT EMPLOYMENT **Employer:** _________________________ **Address:** _________________________ _________________________ **Phone #:** _________________________ **Reason for Leaving:** _________________	Job Title: ____ From: ____/_____/______ to ____/_____/_______ Work Status: ☐ Full-Time ☐ Part-Time ☐ PRN ☐ Contract
For HR Use Only: **DR/CR Experience ☐ Yes ☐ No** **Verifier Initials:** ___________	Describe Your Work Duties: ___________________________ ____ ____ Pay Rate: $_____________ Salaried or Hourly (Circle) Supervisor Name: (First) _____________ (Last) _________ Supervisor Title: ___________________________________
ADDITIONAL WORK EXPERIENCE **Employer:** _________________________ **Address:** _________________________ _________________________ **Phone #:** _________________________ **Reason for Leaving:** _________________	Job Title: ____ From: ____/_____/______ to ____/_____/_______ Work Status: ☐ Full-Time ☐ Part-Time ☐ PRN ☐ Contract
For HR Use Only: **DR/CR Experience ☐ Yes ☐ No** **Verifier Initials:** ___________	Describe Your Work Duties: ___________________________ ____ ____ Pay Rate: $_____________ Salaried or Hourly (Circle) Supervisor Name: (First) _____________ (Last) _________ Supervisor Title: ___________________________________
ADDITIONAL WORK EXPERIENCE **Employer:** _________________________ **Address:** _________________________ _________________________ **Phone #:** _________________________ **Reason for Leaving:** _________________	Job Title: ____ From: ____/_____/______ to ____/_____/_______ Work Status: ☐ Full-Time ☐ Part-Time ☐ PRN ☐ Contract
For HR Use Only: **DR/CR Experience ☐ Yes ☐ No** **Verifier Initials:** ___________	Describe Your Work Duties: ___________________________ ____ ____ Pay Rate: $_____________ Salaried or Hourly (Circle) Supervisor Name: (First) _____________ (Last) _________ Supervisor Title: ___________________________________
Employer: _________________________ **Address:** _________________________ _________________________ **Phone #:** _________________________	Job Title: ____ From: ____/_____/______ to ____/_____/_______ Work Status: ☐ Full-Time ☐ Part-Time ☐ PRN ☐ Contract

SPRINGWOOD HEALTH & SUPPORTIVE LIVING SERVICES

Reason for Leaving: _________________	Describe Your Work Duties: ___________________________
For HR Use Only: **DR/CR Experience** ☐ **Yes** ☐ **No** **Verifier Initials:** ___________	Pay Rate: $_____________ Salaried or Hourly **(Circle)** Supervisor Name: (First) _____________ (Last) _________ Supervisor Title: ___________________________________

PERSONAL REFERENCES

List three (3) personal references we may contact with at least one of the references listed being **a person who has known you for five (5) or more years. PLEASE DO NOT LIST ANY FAMILY MEMBERS OR PREVIOUS SUPERVISORS.**

REFERENCE 1	**REFERENCE 2**	**REFERENCE 3**
Name: ______________________	Name: ______________________	Name: ______________________
Address: ____________________	Address: ____________________	Address: ____________________
____________________	____________________	____________________
Phone: (____)_______________	Phone: (____)_______________	Phone: (____)_______________
Mobile: (____)_______________	Mobile: (____)_______________	Mobile: (____)_______________
Years Known: _______________	Years Known: _______________	Years Known: _______________
Relationship: _______________	Relationship: _______________	Relationship: _______________

RELEVANT TRAINING/ WORK SKILLS

Please list all DIDD/APS/DHS/DBHDD required training you have completed within the last year. You will need to link your RELIAS account to Springwood Health and/or submit copies prior to being employed.

____
____
____

RESIDENTIAL HISTORY

Please list all residences you have had for the past seven (7) years.

Address	City	State	County	Dates

EMPLOYEE NON-DISCLOSURE ACKNOWLEDGMENT

SPRINGWOOD HEALTH & SUPPORTIVE LIVING SERVICES

Springwood Health & Supportive Living Services, LLC (and all companies owned by same) has a legal and ethical responsibility to safeguard the privacy of all clients and protect the confidentiality of their health information. In the course of my employment at Springwood Health, I may come into possession of confidential client information, even though I may not be directly involved in providing client services.

I understand that such information must be maintained in the strictest confidence. As a condition of my employment, I hereby agree that, unless directed by my supervisor, I will not at any time during my employment with Springwood Health disclose any client information to any person whatsoever, to examine or make copies of any client reports or other documents prepared by me, coming into my possession or under my control, or use client information other than as necessary in the course of my employment.

When client information must be discussed with other health care practitioners in the course of my work, I will use discretion to insure that such conversations are conducted privately outside of the hearing of those who are not directly involved in the clients care. I understand that violation of this agreement may result in disciplinary action, up to and including termination of my employment.

Signature: ____ Date: ___________________________

PRE/POST EMPLOYMENT BACKGROUND INVESTIGATIONS/DRUG SCREENING POLICY

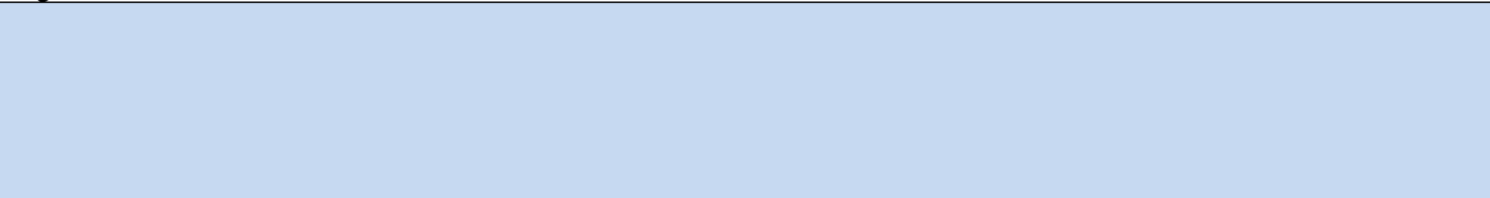
As a condition of employment with Springwood Health & Supportive Living Services, LLC, all applicants and employees are subject to pre-employment and random drug screens. An initial drug screen is required upon an applicant being offered a position with the company. Successful completion of a criminal background check, DIDD/APS/DHS/DBHDD history check, credit history check (if applicable to position being hired in), driver license (MVR) check, educational history and employment history verification must be successfully completed prior to an employee beginning employment with Springwood Health & Supportive Living Services, LLC. Offers of employment will be withdrawn for all applicants who fail to successfully complete these pre-employment requirements.

Applicants who successfully complete the pre-employment process and who are hired to work with Springwood Health & Supportive Living Services, LLC are subject to random drug testing and review of their driver license history (MVR) throughout their tenure with the company. Employees who fail the random drug testing protocol, who have criminal offenses deemed to threaten the integrity and proper functioning of the organization, or who fail to maintain a valid Tennessee Driver License are subject to immediate termination of their employment.

Your signature indicates you have read the above documented employment policy and agree to abide by this policy throughout your tenure with Springwood Health & Supportive Living, LLC. Springwood Health & Supportive Living, LLC reserves the right to modify its policies and procedures at any time; through the submission of a notice of policy adjustment/change to its employees.

____ _____/_____/______________

Signature Date



SPRINGWOOD HEALTH & SUPPORTIVE LIVING SERVICES

DIDD/APS/DHS/DBHDD EMPLOYEE ACKNOWLEDGEMENT

I, the undersigned applicant, certify and affirm that, to the best of my knowledge and belief; I ["have" or "have not," as applicable] had a case of abuse, neglect, mistreatment or exploitation substantiated against me. As a condition of submitting this application and in order to verify this affirmation, I further release and authorize Springwood Health, the Tennessee Department of Intellectual and Developmental Disabilities and the Bureau of TennCare to have full and complete access to any and all current or prior personnel or investigative records, from any party, person, business, entity or agency, whether governmental or non-governmental, as pertains to any allegations against me of abuse, neglect, mistreatment or exploitation and to consider this information as may be deemed appropriate. This authorization extends to providing any applicable information in personnel or investigative reports concerning my employment with this employer to my future employers who may be Providers of DIDD/APS/DHS/DBHDD services.

____ ____________________

Signature *Date*

STATEMENT FOR RELEASE OF INFORMATION ***(Tennessee Use Only)***

Date: _______________

Name of Agency & Region: Springwood Health – __West __Middle __East

Full Name of Employee: ______________________________________

Previously used names (nicknames, maiden name, etc.):
____

SS#: _______________________________

DL#: _______________________________

State of DL: _________________________

Hire Date: _________________________

I, ____________________, certify and affirm that to the best of my knowledge and belief, I

have or **have not** (circle one)

received a finding of a substantiated case of abuse, neglect, mistreatment, or exploitation against me. In order to verify this affirmation, I further release and authorize *Springwood Health* and the Tennessee Division of Mental Retardation Services to have full and complete access to any and all personnel or investigative records as pertains to any substantiated allegations against me of abuse, neglect, mistreatment, or exploitation.

Signature of Employee: _______________________________

Date: ___________________

Agency Witness: ________________________________

Date: ___________________

SPRINGWOOD HEALTH & SUPPORTIVE LIVING SERVICES

MEDICATION ADMINISTRATION/OBSERVATION STATUS

DEAR CANDIDATE FOR EMPLOYMENT/EMPLOYEE:

Springwood Health & Supportive Living Services, LLC provides comprehensive services to persons with disabilities. Persons who administer/observe medications while employed by Springwood Health must be certified by the Tennessee DIDD. Your signature below grants Springwood Health the right to provide your name, date of birth and social security number to this government agency to determine your eligibility for certification. This information may also be used to determine the status of your current certification to include the date of expiration.

Once employed, a candidate may not administer/observe medications until they have been certified by the State of Tennessee or Springwood Health. Medications may not be administered/observed until an employee has attended and successfully completed recertification training. **If you are already certified and are entering re-certification class to keep your certification current, your present certification expires the first day you attend recertification class. This is regardless of whether you have additional days left on the old certification and even applies if you decide not to test at the completion of the certification.**

DO NOT GIVE/OBSERVE MEDICATIONS until you have been officially notified that you passed the examination and are now eligible to perform this job function. When in doubt, **DO NOT ADMINISTER/OBSERVE MEDICATIONS!!!!!!!!** Persons who violate this expectation will be terminated from employment with Springwood Health.

Your signature below grants approval for Springwood Health to proceed with verification of your status. Failure to agree to this provision eliminates you from consideration as a future employee of Springwood Health.

______________________________________ ______________________
Printed Name Date

____
Signature

SPRINGWOOD HEALTH & SUPPORTIVE LIVING SERVICES

Equal Employment Opportunity Tracking Data

Facility/Site Location: ____

This form is kept for Affirmative Action statistical and reporting purposes only. It will be filed separately from your application for employment and will have no bearing on the selection process for employment with Springwood Health & Supportive Living Services.

Date of Application: _____/_____/_________ Position(s) Applied for: _______________________________________

Mailing Address: ____

Phone #: (_____) ______- _______ Birth Date: _____/_____/_____ Age: ______ ☐ Male ____ Female ____

RACE

☐____ American Indian/Alaska Native ☐ _____Asian ☐ _____Black/African American
☐___ Native Hawaiian/Pacific Islander ☐ _____White ☐ _____Hispanic/Latino (All Other Races)
☐___ Hispanic/Latino (White Race Only) ☐ Other _________________________

If you are and individual with a disability, a special disabled veteran, a veteran of the Vietnam era, or other campaigns, you are invited to identify yourself at this time. You will not be subject to adverse treatment regardless of whether you choose to self-identify. This information will be used for affirmative action purposes only.

Veteran: ___ Yes ___ No Vietnam Veteran: ___ Yes ___ No Other Operations/Campaigns : ___ Yes ___ No

Disability: ___ Yes ___ No Special Disabled Veteran: ___ Yes ___ No

REFERRAL SOURCE

☐ Posted Job Announcement ☐ Newspaper Ad ☐ Radio/TV ☐ Walk- In ☐ Current Employee (list name below)

☐ Correspondence ☐ Career Center ☐ Other (List) ____

____

ACTION TAKEN

☐ **Hired** ☐ **Not Hired** ☐ **Date of Hire** ____/_____/_______

☐ **Offer** ☐ **Offer Accepted** ☐ **Offer Rejected** ____/____/_______

Springwood Health & Supportive Living Serivces is an Equal Opportunity Employer and is committed to hiring qualified applicants without regard to race, religion, gender, national origin, disability, age and/or other protected classes identified by United States of America.

SPRINGWOOD HEALTH & SUPPORTIVE LIVING SERVICES

PERSON-CENTERED HOBBY LIST

Employees and Supported Persons

Hobby or Interest	Place X if you enjoy	Hobby or Interest	Place X if you enjoy
Airplanes (watching)		Going to Movies	
Animals Pets		Going to Museums	
Arts		Hair Styling	
Badminton		Hiking	
Basketball		Jigsaw Puzzles	
Baking		Kites	
Bird Watching		Listening to Music	
Board Games		Making Jewelry	
Bowling		Painting Fingernails	
Butterflies		Pottery	
Church Activities		Reading	
Cloud Watching		Riding Bicycles	
Computer Activities		Sewing	
Cooking		Shopping	
Crafts		Singing	
Crossword Puzzles		Swimming	
Dancing		Television	
Digital Photography		Traveling	
Dominoes		Video Games	
Drawing		Visiting Parks	
Exercising		Volleyball	
Football		Walking	
Fishing		Writing	

Other Hobbies Not Listed: ____

____

_________________________ _________________________ ____________
Print Name Signature Date

SPRINGWOOD HEALTH & SUPPORTIVE LIVING SERVICES

FAIR CREDIT REPORTING ACT
DISCLOSURE AND AUTHORIZATION

Through this document, it is being disclosed to me and I understand that a Consumer Report or Investigative Consumer Report may be prepared about me as a part of my employment and/or continued employment (this includes volunteers and contracts for service). An "investigative consumer report" includes information as to your character, general reputation, personal characteristics and mode of living.

I authorize **Springwood Health** to procure a Consumer Report from ADP background services, Inc. and its agents to retrieve necessary information and prepare such Consumer Report. If an Investigative Consumer Report is procured then "A Summary of Your Rights under the Fair Credit Reporting Act" will be provided to you at the time you receive this disclosure and authorization. I understand that my consent will apply throughout my employment, to the extent permitted by law.

I may request a copy of any report that is prepared regarding me and "A Summary of Your Rights, under the Fair Credit Reporting Act". I may also request the nature and substance of all information about me contained in the files of the consumer reporting agency. I understand I have a right to inspect those files with reasonable notice during regular business hours. The consumer reporting agency is required to provide someone to explain the contents of my file. I understand proper identification will be required and I should direct my request to: **Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

May your current employer be contacted ☐ yes ☐ no ☐ not currently employed ☐ post hire only

California – Are you employed in, seeking employment in or a resident of CA ☐ yes ☐ no

California, Minnesota, or Oklahoma – Are you employed in, seeking employment in or a resident of one of these states? If so, do you wish to receive a copy of any Consumer Report of which you are the subject of? ☐ yes ☐ no

Maine and New York – You have the right, upon request, to be informed of whether a Consumer Report about you was requested by the above name company.

Signature of Applicant or Employee	Date

The following is for identification purposes (to perform the background check and will not be used for any other

First Name	Middle Name	Last Name

Drivers License #	State Issued
Social Security Number	Date of Birth

Current Address	City

State	Zip Code	County	Length at Address

Previous Address – list any counties, cities, states you have lived in the previous 7 years
Other Names – list any other last names you have used in the previous 7 years
Education - List any other last name under which you received your GED, High School Diploma or other academic credentials

SPRINGWOOD HEALTH & SUPPORTIVE LIVING SERVICES

Springwood Health & Supportive Living Services, LLC
1661 International Drive Ste 400
Memphis, TN 38120
Office: 901.825.3048

DISCLOSURE AND AUTHORIZATION TO RELEASE INFORMATION

I understand that in connection with my application for employment (or promotion), a consumer report may be requested. This report may contain information as to my character, general reputation, personal characteristics or mode of living. I hereby authorize and request any former employer, school, law enforcement agency, financial institution or other persons having personal knowledge about me to furnish ADP with any and all information in their possession regarding me, in connection with an application for employment. I understand and offer my consent for ADP to inquire into and/or obtain any records such as previous employment, references, educational, motor vehicle records, workers compensation, credit and criminal histories. I acknowledge that a photocopy or fax of this authorization be accepted with the same authority as the original. According to the Fair Credit Reporting act, I am entitled to know if employment is denied because of information obtained from the Consumer Reporting Agency. If so, I will be notified and given the name and address of the agency or the source, which provided the information.
I understand that my consent will apply throughout my employment, to the extent permitted by law. I have read and understand this disclosure and consent form.

____
Signature of Applicant Date

____
Applicants Full Name (please print)

____
Please print other names you have used

The following is for identification purposes (to perform the background check and will not be used for any other purpose)

Driver's License #: ______________________________ State issued: ______________________________

Social Security Number______________________________ Date of Birth ______________________

____
Current Address City State Zip Code County Length at address

____
Former Address City State Zip Code County Length at address

____
Former Address City State Zip Code County Length at address

____
Former Address City State Zip Code County Length at address

NOTE: WE NEED ALL ADDRESSES FOR THE PAST SEVEN YEARS

Employee Name (Printed) ____

SPRINGWOOD HEALTH & SUPPORTIVE LIVING SERVICES

I am available to work PRN (as needed) the following days and times.

Please circle any and all shifts listed below that you are available to work.

Saturday	**7/8am – 7/8pm**	**7/8pm – 7/8am**	**Other: ___________________**
Sunday	**7/8am – 7/8pm**	**7/8pm – 7/8am**	**Other: ___________________**
Monday	**7/8am – 3/4pm**	**3/4pm-11/12pm**	**11/12pm-7/8am**
Tuesday	**7/8am – 3/4pm**	**3/4pm-11/12pm**	**11/12pm-7/8am**
Wednesday	**7/8am – 3/4pm**	**3/4pm-11/12pm**	**11/12pm-7/8am**
Thursday	**7/8am – 3/4pm**	**3/4pm-11/12pm**	**11/12pm-7/8am**
Friday	**7/8am – 3/4pm**	**3/4pm-11/12pm**	**11/12pm-7/8am**

Do you foresee your availability changing in the near future? If so, please be specific as to why in the space provided.

____

____

____

____

My signature below indicates that:

- ***I understand that this form is for the sole purpose of determining my availability to work and in no way constitutes a contract or guarantee that I will be working these times.***
- ***It also does not indicate acceptance by the company of my availability.***
- ***I agree to submit a new form to the HR Department should my available change.***

____ ____________________

Employee Signature **Date**

The Springwood Health Application Process:

- **We keep your application on file and active for a period of 6 months from the date you submit it.**
- **When we have an open position we will pull applications and choose the best candidates to interview for each opening.**
- **Due to the high volume of applicants, we are unable to take phone calls to check on application status.**
- **If you do not receive an interview or phone call within the 6 month period then you may resubmit your application.**

We appreciate your cooperation

PLEASE TEAR OFF AND KEEP FOR YOUR RECORDS