ALLEGRO CONCIERGE CARE

APPLICATION FOR EMPLOYMENT

Date: _____

Position Appling For _____ Desired Salary _____

Date Available _____

Personal Information

Name

_____

First Middle Last

Please list all the names you have previously used including maiden names: _____

Date of Birth _____ Social Security Number _____

Are you a U S citizen? ☐ Yes ☐ No

_____

Address City State Zip

Residence addresses for the Past 3 Years: (attach additional sheets, if necessary)

Street Address, City, State, Zip From Mo/Yr Current Address: To Mo/Yr.

_____

_____

_____

_____

_____

Home Number _____ Cell Number _____

Email Address (required) _____

How did you hear about Allegro Concierge Care?

_____

Were you referred by anyone?

_____

Have you ever been convicted of a felony or misdemeanor within the past 5 years (Conviction includes pleas of guilty and *nolo contendere*)? ☐ Yes ☐ No

Please include dates and explain:

_____

_____

Education				
School	**Location**	**Years Attended**	**Degree Received**	**Major**

Other training certificates held _____

_____

Has your license or certification ever been suspended, revoked, or reprimanded: ☐ Yes ☐ No

If yes, please explain _____

_____

_____

_____

COMPANY EXPERIENCE

Have you worked for Allegro Concierge Care before? _____

Dates: From _____ To _____
Month/Year Month/Year

Rate of Pay _____ Position _____

Reason for leaving _____

_____

Employment History

(Begin with the most recent employer)

Company Name	Dates worked		Position(s) Held
	From	To	
Address, City, State, Zip	Starting Wages	Ending Wages	Work Hours
Phone Number			
Type of Business	Reason for Leaving		
Name of Supervisor			
Duties/Responsibilities			

Company Name	Dates worked		Position(s) Held
	From	To	
Address, City, State, Zip	Starting Wages	Ending Wages	Work Hours
Phone Number			
Type of Business	Reason for Leaving		
Name of Supervisor			
Duties/Responsibilities			

Company Name	Dates worked		Position(s) Held
	From	To	
Address, City, State,Zip	Starting Wages	Ending Wages	Work Hours
Phone Number			
Type of Business	Reason for Leaving		
Name of Supervisor			

Duties/Responsibilities

Professional References

(Please provide 3 or more references)

1.Name		Year Known	Relationship and Title	
Company				
Work Address	City	State	Home Phone	Work Phone

2.Name		Year Known	Relationship and Title	
Company				
Work Address	City	State	Home Phone	Work Phone

3.Name		Year Known	Relationship and Title	
Company				
Work Address	City	State	Home Phone	Work Phone

Personal References

Name: _____

Relation to applicant: _____ Years Known: _____

Phone: _____

Comments:

_____

_____

Personal Reference

Name: _____

Relation to applicant: _____ Years Known: _____

Phone: _____

Comments:

_____

_____

Personal Reference

Name: _____

Relation to applicant: _____ Years Known: _____

Phone: _____

Comments:

_____

_____

Attestation of Exclusion and Conviction

Exclusion of certain individuals and entities from participation in Federal Health Programs (Medicare, Medicaid, Tricare, Federal Employees) and State Health Care Programs are mandated under the following codes.

51128 [42 U.S.C. 1320a-7] (a) MANDATORY EXCLUSION. The Secretary shall exclude the following individuals and entities from participation in any Federal health care program (as defined in 51128B(f)]:

(1) Conviction of program-related crimes. Any individual or entity that has been convicted of a criminal offence related to the delivery of an item or service under Title XVII or under any state Health Care Program.
(2) Conviction relating to patient abuse. Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect of abuse of patients in connection with the delivery of a health care item or service.
(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD. Any individual or entity that has been convicted of an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability act of 1996, under Federal of State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE. Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance. [781]

(b) PERMISSIVE EXCLUSION. The Secretary my exclude individuals and individuals from participation in any Federal health care program as listed 9as defined in 51128B(f).

These Permissive Exclusions are for misdemeanors of the above offenses plus other infractions that will be determined on an individual case-by-case basis.

OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW.

51156 [42 U.S. 1320C-5] : It shall be the obligation of any health care practitioner and any other person (including a hospital or other healthcare facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act

(1) Will be provided economically and only when, and to the extent, medically;
(2) Will be of a quality which meets professionally recognized standards of health care; and
(3) Will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

ATTESTATION OF EXCLUSION AND CONVICTION

I agree to inform my supervisor or Director of Human Resources within five (5) days of receipt if, during my employment or association with Allegro Concierge Care, I receive notice of exclusion or sanction or I am convicted of a crime described above.
My signature below indicates that I have read the listing of exclusions and obligations above and state honestly under penalty of law that:

I have been excluded of convicted of any of the above.

_____ _____

Date Signature: Printed Name

Or

I have **NOT** been excluded or convicted of any of the above.

_____ _____

Date Signature: Printed Name