MPATH ASSISTIVE CARE

Contents

EMPLOYMENT APPLICATION

INSTRUCTIONS: If you need help filling out this application form or for any phase of the employment process, please notify the person who gave you this form and every reasonable effort will be made to meet your needs in a reasonable amount of time.

- Please read "Applicant Note" below.
- Complete all pages of this application.

□ Print clearly. Incomplete or illegible applications may not be accepted.

□ If more space is needed to complete any question, use the back of the document.

APPLICANT NOTE: This application form is intended for use in evaluating your qualifications for employment with us, an independently owned and operated Home Care Agency. This is not an employment contract. Please answer all appropriate questions completely and accurately. False or misleading statements during the interview and on this form are grounds for terminating the application process or, if discovered after employment begins, terminating employment. All qualified applicants will receive consideration and will be treated throughout their employment without regard to race, color, religion, sex, national origin, age, disability, or any other protected class status under applicable law. Additional testing for the presence of illegal drugs in your body may be required prior to employment.

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PERSONAL INFORMATION Today's Date: _____

Positions(s) Applied For: HHA_____CNA_____

Name: _____ _____ _____
Last First Middle

Current Address: _____ _____ _____ _____
Street City State Zip Code

Years at current address_____ DOB: _____

Previous Address: _____ _____ _____ _____
Street City State Zip Code

Years at current address_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Emergency Contact(s): _____ (_____) _____
Name Phone

_____ (_____) _____
Name Phone

Have you ever submitted an application here before? **Yes / No** If yes, when? _____

Have you ever been employed here before? **Yes / No** If yes, when? _____

How did you hear about MPath Assistive Care LLC? ____Indeed.com_____Facebook _____Referral

Name of Referral if applicable _____

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AVAILABILITY

Due to the nature of the business, no guarantee can be made as to the schedule or the amount of hours worked.

What date are you available to begin work? _____ Please complete all areas of availability:

_____Mornings _____Afternoon _____Evenings _____Overnights ____Weekdays _____Weekends

Please indicate the days of the week as well as the earliest and latest times that you are available for work.

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Shift	From:							
	To:							

PREFERENCES

Please indicate all areas of the city in which you are willing to work:

_____

Please indicate the types of services which you are willing to provide:

	Companionship		Housekeeping (dust/vacuum)		Errands/Shopping
	Meal Preparation		Laundry/Ironing		Personal Care
	Activities (games/crafts)		Medication Reminders		Dementia/Alzheimer's Care

Are you willing to provide service to a client with a pet? Yes / No If yes, which ones: _____Cats _____Dogs

Are you willing to provide service to a client that smokes? Yes / No

EDUCATION

Highest Grade Completed _____

School Type	School Name	City, State	Major/Subject	# Yrs Attended	Graduate
High School					Y / N
Vocational/Technical					Y / N
College/University					Y / N

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WORK HISTORY

Your application will not be considered unless all questions in this section are answered. Since we will make every effort to contact previous employers, the correct telephone numbers of past employers are essential.

MOST RECENT EMPLOYER

Are you currently working for this employer? **Yes / No** If yes, may we contact? **Yes / No**

_____ _____ _____ (____)_____

Company Name City State Phone Number

Dates Employed: From _____ to _____ _____ _____

Job Title Supervisor's Name

_____

Duties

$_____ per _____ _____

Salary (Hour, Week, Month) Reason for Leaving

SECOND MOST RECENT EMPLOYER

_____ _____ _____ (____)_____

Company Name City State Phone Number

Dates Employed: From _____ to _____ _____ _____

Job Title Supervisor's Name

_____

Duties

$_____ per _____ _____

Salary (Hour, Week, Month) Reason for Leaving

THIRD MOST RECENT EMPLOYER

_____ _____ _____ (____)_____

Company Name City State Phone Number

Dates Employed: From _____ to _____ _____ _____

Job Title Supervisor's Name

_____

Duties

$_____ per _____ _____

Salary (Hour, Week, Month) Reason for Leaving

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SECURITY

Have you been charged/convicted of a felony and/or misdemeanor/or served time **Yes / No**

If yes, please describe: Incident City/State Charge

Have you ever been a charged perpetrator or appeared on any child abuse registry in the last 5 years? **Yes or No.**

If yes, please describe: Incident City/State Charge

REFERENCES (Do not include relatives)

Please complete all three references. Your application will not be considered unless three references are provided. Since we will contact these references, please notify them in advance. If we are unable to reach all 3 references, you will be asked to provide additional references.

Full Name	Phone Number	E-Mail Address	Best Time of Day to Call	Relationship	# of Years Known
1)	H ( ) W ( )		AM / PM AM / PM		
2)	H ( ) W ( )		AM / PM AM / PM		
3)	H ( ) W ( )		AM / PM AM / PM		

CERTIFICATION AND RELEASE: I certify that I have read and understand the applicant note on page one (1) of this form and that the answers given by me to the foregoing questions and the statements made by me are complete and true to the best of my knowledge and belief. I understand that any false information, omissions or misrepresentations of facts in this application may result in rejection of my application or discharge at any time during my employment. I authorize the company and/or its agents, including consumer-reporting bureaus, to verify any of this information including, but not limited to, criminal history and/or motor vehicle driving records. I authorize all persons, schools, companies and law enforcement authorities to release any information concerning my background and hereby release any said persons, schools, companies and law enforcement authorities from any liability for any damage whatsoever for issuing this information. I release this company from any liability which might result from making such investigations. I also understand that the use of illegal drugs is prohibited during employment. I am willing to submit to drug testing to detect the use of illegal drugs prior to and during employment. I understand that this application is not a contract of employment. My employment is contingent upon confirmation of credentials and successful completion of drug test or criminal background check. I also understand that if hired, regardless of any oral presentations to the contrary, the employment relationship between MPath Assistive Care LLC, and myself is terminable at-will, so that both the company and I remain free to choose to end out work relationship at any time for any or no reason. Any changes in this employment relationship must be made in writing. My signature below acknowledges that I have read, understand, and agree to the above disclosure. I also understand that due to the nature of the business, no amount of work can be guaranteed.

APPLICANT SIGNATURE **DATE**

CONSENT TO EMPLOYEE DRUG AND/OR ALCOHOL TESTING

I understand that submission to a Pre or Post-Injury Drug And/Or Alcohol Screen is a condition of employment with this employer. I understand that, should my testing results be confirmed positive or I refuse to test, I will be subject to the company's disciplinary action, including possible discharge. I understand that a tampered with or an adulterated specimen will be considered a refusal to test, resulting in possible discharge.

I hereby give my consent to release the results of my blood and/or urinalysis to the person(s) or department(s) or the specified agent of my employer, including my employer's Workers' Compensation Insurance Company, for the purpose of determining the presence of alcohol and/or other drugs in my body for the duration of my employment.

I understand that if I am injured during the course and scope of my employment and I test positive for the presence of alcohol and/or drugs, I may forfeit my eligibility for medical and indemnity benefits. I also understand that a refusal to test, a tampered with or an adulterated specimen under this circumstance may also result in forfeiture of my eligibility for medical and indemnity benefits and immediate action, including possible discharge.

By signing this form, I hereby release to the Company and/or Company's Medical Review Officer the results of the test(s) to which I have consented. I further authorize the Company to discuss the results with medical personnel / physician collecting the specimen, the testing facility, its directors, officers, agents, and employees responsible for administering the aforementioned test(s) or evaluating the results thereof and any of them herein. I also authorize the Company to discuss the results with its legal advisors and to use the test results as a defense to any legal action to which I am a party. I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical records, and data concerning my test(s) to the appropriate Employer officials. I agree to have the results released to the Company and/or the Company's Medical Review officer.

Employee or Applicant Signature: _____ Print Name: _____

Date: _____ (Parent or Guardian Signature if Employee is a Minor)

Employee or Applicant S/S.#: _____ Witness: _____

Date: _____

OR

I hereby refuse to consent to submit testing for the presence of drugs and/or alcohol.

Employee or Applicant Signature: _____ Print Name: _____

Date: _____ (Parent or Guardian Signature if Employee is a Minor)

Employee or Applicant S/S#: _____

Witness: _____ Date: _____

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EMPLOYEE CONSENT FOR REFERENCE CHECK

To Whom It May Concern:

I give, _____

my former employer, authorization to provide a reference check to my potential employer.

I am aware and acknowledge the information referred to above is not shared with any third parties. By signing below I give the employer consent to collect the information contained herein and use for the purpose specified.

Signed

_____

Print Name

_____

Address

_____

_____

_____

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NON-COMPETE & CONFIDENTIALITY AGREEMENT

SIGNATORIES agree to sign this contract with a sound mind that they will remain honest and loyal to MPath Assistive Care LLC.

Also they will agree to remain professional at all times, if there is any situation that you may feel uncomfortable at time or if a client tries to hire you outside of the MPath Assistive Care LLC you will notify the proper authority at once.

- You may not advertise your service as a home care professional or for any types of service for that matter to anybody that is under the contract or that has been under the contract of MPath Assistive Care LLC. During the duration of your employment with this company or two years after working for this company, if so, you could be found guilty of violating this non-compete agreement and will be charged a “finder’s fee of $5,000 including court costs”.

- Also you may not discuss any condition with anyone other than the company or with the clients POA , as well as show, or copy any documentations or medical records belonging to the client or to MPath Assistive Care LLC, or you can be held in violation of the confidentiality agreement and can be sued.

- You are also giving MPath Assistive Care LLC permission to use this document in a legal setting. Without being charged with slander or without risk of legal responsibility. If we have a reason to believe that this contract has been breached in anyway.

Name of Employee_____ Date_____

Name of Employer_____ Date_____

Client Rights and Responsibilities and Prohibitions Client Rights:

1. To be involved in the service planning process and to receive services with responsible accommodation of individual needs and preferences, except where the health and safety of the direct care worker is at risk. PA Code 611.57 (a).
2. To receive at least 10 calendar days advance written notice of the intent of the home care agency to terminate services. Less than 10 days advance written notice may be provided in the event the consumer has failed to pay for services, despite notice, and the consumer is more than 14 days in arrears, or if the health and welfare of the direct care worker is at risk. PA Code 611.57(a)
3. You have the right to considerate, respectful, and nondiscriminatory care.
4. You have the right to privacy.
5. You have the right to receive information about rules involving your care or conduct.
6. You have the right to know who is taking care of you and his/her professional titles.
7. You have the right to be involved in the implementation and review of your plan of care.
8. You have the right to a copy of your services schedule at least one week in advance.
9. You have the right to receive care that is compliant with sanitary and safety standards.
10. You have the right to details about all items on your bills.
11. You have the right to express any concerns you may have regarding your care. We encourage you to communicate concerns or compliments to the MPath Assistive Care LLC office.

Consumers' Responsibilities/Prohibitions:

1. No individual as a result of the individual's affiliation with a home care agency may assume power of attorney or guardianship over a consumer utilizing the services of that home care agency. The home care agency may not require a consumer to endorse checks over to the home care agency. PA Code 611.57(b).

2. Employees are prohibited from maintaining fiduciary relationships, such as representative payee or power of attorney, with clients or other caregivers of the client, and employees are prohibited from managing a clients' personal funds. You may not allow our employees to engage in those practices.

3. Employees will not allow themselves to be appointed as a legal guardian to any client, no to be appointed or listed as a beneficiary of any client. You may not allow our employees to engage in those practices. 4.

Employees are prohibited from soliciting gifts, favors, money, or other items of value from clients. It is expressly forbidden to accept and gifts or gratuity, or to solicit or ask for any gift or item from the clients' home, even if the item is scheduled to be thrown away, to be put into the trash, or donated to charity. You are to contact our office if any solicitation is made and you are not to offer our employees any gifts, gratuities, favors, money, or other items of value even if you intend to throw away, to be put into the trash, or donated to charity.

5. You are responsible for disclosing relevant information related to you plan of care and for making it known whether you clearly understand your plan of care.
6. You are responsible for clearly communicating wants and needs.
7. You are responsible for notifying the MPath Assistive Care LLC office in advance of any schedule changes.
   8. You are responsible for the provision of soap, paper towels, and any other items necessary to keep you and your environment sanitary and safe.
9. You are responsible for showing respect to MPath Assistive Care LLC personnel through your language and actions.
10. You are responsible for meeting the agreed upon financial obligation to MPath Assistive Care LLC.

Employee Acknowledgement with Signature Date

PRE-EMPLOYMENT BACKGROUND CHECK AUTHORIZATION

I, _____,
understand that as part of the employment process, MPath Assistive Care LLC may complete a background check on me regarding:

1. Criminal record;
2. Sex and Violent Offenders Record;
3. Employment Verification;
4. Education Verification;
5. License Verification;
6. Motor Vehicle Records;
7. Personal/Professional Reference Verification;
8. Medical Suitability
9. 9. Drugs/Alcohol

○ I authorize all federal and state agencies, persons and organizations that may have information relevant to this research to disclose such information to MPath Assistive Care LLC or its authorized agent(s). ○ I understand that this authorization is to be part of the written and signed employment application. ○ I also understand that I do not have to give authorization for a background check but if I don't give permission, my employment application will not be processed further. ○ I understand that I have specific rights under the federal Fair Credit Reporting Act (FCRA) and may have additional rights under relevant State law. ○ I further authorize that a photocopy of this authorization may be considered as valid as the original. ○ I hereby certify that all statements on this form are true and correct to the best of my knowledge and belief. I understand that employment with MPath Assistive Care LLC is contingent upon successful completion of a background check.

_____ _____
Signature Date

Full Name _____ Telephone No._____

Former Name(s) and Date(s) used: _____

Current Address_____

Date of Birth_____ Social Security Number: _____

Current Driver's License: _____ State: _____

List any other cities, states and dates of residency during last 10 years (Use back of sheet, if necessary.)

City State From: Month/Year To: Month/Year

_____ _____ _____ _____