



## JOB APPLICATION

# Care Planning Solutions, LLC

PO Box 104973, Jefferson City, Missouri 65110

573-298-0865

573-257-1378

Care Planning Solutions is an equal opportunity employer. This application will not be used for limiting or excluding any applicant from consideration for employment on a basis prohibited by local, state, or federal law. Should an applicant need reasonable accommodation in the application process, he or she should contact a company representative.

*Please fill out all of the sections below:*

### **Applicant Information**

***Applicant Name:*** \_\_\_\_\_

***Address:*** \_\_\_\_\_

***City, State and Zip Code:*** \_\_\_\_\_

***Telephone Number:*** \_\_\_\_\_

***Email Address:*** \_\_\_\_\_

***Date of Birth:*** \_\_\_\_\_

***SSN:*** \_\_\_\_\_

***Date of Application:*** \_\_\_\_\_

### **Employment Position**

***Position(s) applying for:*** Home Health Aide (full time)

How did you hear about this position? \_\_\_\_\_

What days are you available for work? \_\_\_\_\_

What hours or shift are you available for work? \_\_\_\_\_

If needed, are you available to work overtime? \_\_\_\_\_

On what date can you start working if you are hired? \_\_\_\_\_

Do you have reliable transportation to and from work? \_\_\_\_\_

Salary desired: \_\_\_\_\_

### **Personal Information**

Do you have any friends, relatives, or acquaintances working for Care Planning Solutions?

Yes      No

If yes, state name & relationship:

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Have you ever been known by any other name(s)? Yes    No  
Please list any previous names:

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Are you 18 years of age or older? Yes    No

Have you lived outside of the state of Missouri? Yes    No

If you answered yes to above question, please list other states resided in and dates of residence:

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Are you a U.S. citizen or approved to work in the United States? Yes    No

What document can you provide as proof of citizenship or legal status?

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Will you consent to a mandatory controlled substance test? Yes    No

Do you have any condition which would require job accommodations? Yes    No

If yes, please describe accommodations required below.

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Have you ever been convicted of a criminal offense (felony or misdemeanor)? Yes    No

If yes, please state the nature of the crime(s), when and where convicted and disposition of the case:

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**Job Skills/Qualifications**

Please list below the skills and qualifications you possess for the position for which you are applying:

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*(Note: Care Planning Solutions complies with the ADA and considers reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions. )*

**Education and Training**

**High School**

Name	Location (City, State)	Year Graduated	Degree Earned

**College/University**

Name	Location (City, State)	Year Graduated	Degree Earned

**Vocational School/Specialized Training**

Name	Location (City, State)	Year Graduated	Degree Earned

**Military:**

Are you a member of the Armed Services? \_\_\_\_\_

What branch of the military did you enlist? \_\_\_\_\_

What was your military rank when discharged? \_\_\_\_\_

How many years did you serve in the military? \_\_\_\_\_

What military skills do you possess that would be an asset for this position?

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**Previous Employment**

**Employer Name:** \_\_\_\_\_

Job Title: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Employer Telephone: \_\_\_\_\_

Dates Employed: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**Employer Name:** \_\_\_\_\_

Job Title: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Employer Telephone: \_\_\_\_\_

Dates Employed: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**Employer Name:** \_\_\_\_\_

Job Title: \_\_\_\_\_  
 Supervisor Name: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 City, State and Zip Code: \_\_\_\_\_  
 Employer Telephone: \_\_\_\_\_  
 Dates Employed: \_\_\_\_\_  
 Reason for leaving: \_\_\_\_\_

**References**

Please provide 3 personal and professional reference(s) below:

Reference	Contact Information

**AT-WILL EMPLOYMENT**

The relationship between you and the Care Planning Solutions is referred to as "employment at will." This means that your employment can be terminated at any time for any reason, with or without cause, with or without notice, by you or the Care Planning Solutions. No representative of Care Planning Solutions has authority to enter into any agreement contrary to the foregoing "employment at will" relationship. You understand that your employment is "at will," and that you acknowledge that no oral or written statements or representations regarding your employment can alter your at-will employment status, except for a written statement signed by you and either the Company's Owner(s).

By signing below you give Care Planning Solutions permission to run all applicable background check(s), FCSR screenings, and to contact references and previous employers. I certify that the information contained in this application is correct to the best of my knowledge. I understand that to falsify information is grounds for refusing to hire me, or for discharge should I be hired. I authorize any person, organization or company listed on this application to furnish you any and all information concerning my previous employment, education and qualifications for employment. I also authorize you to request and receive such information. In consideration for my employment, I agree to abide by the rules and regulations of the company, which rules may be changed, withdrawn, added or interpreted at any time, at the company's sole option and without prior notice to me. I also acknowledge that my employment may be terminated, or any offer or acceptance of employment withdrawn, at any time, with or without cause, and with or without prior notice at the option of the company or myself.

Applicant Name (Print): \_\_\_\_\_ Dated: \_\_\_\_\_  
 Applicant Signature: \_\_\_\_\_

\*If submitting electronically leave signature line blank, signature will be required at time of interview.