Hands That Help Personal Care, LLC
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, print comments section on the back.
- Application will be valid for 60 days.

APPLICANT NOTE: This application form is intended for use in evaluating your qualifications for employment with us, Hands That Help Personal Care, LLC. 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.

PERSONAL INFORMATION

Today's Date: _____

Positions(s) Applied For: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Email Address: _____

Name: _____ _____ _____
Last First Middle

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

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

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

Valid Driver's License #: _____ State Issued: _____

Expiration Date: _____

Make & Model of Vehicle: _____ Year of vehicle: _____

Auto Insurance Company: _____ Policy #_____

Expiration Date: _____

AVAILABILITY

Due to the nature of the business, no guarantee can be made as to the schedule or the number 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
From:							
To:							

PREFERENCES

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

___Milwaukee ____Ozaukee _____Racine _____Waukesha _____Kenosha _____Washington

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

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

**To be able to provide transportation or run errands, you will be required to have a valid driver's license and current auto insurance. A motor vehicle record check will be conducted, and proof of insurance will be required.*

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 *

Please circle highest grade completed:

Grade School: 6 7 8 High School: 9 10 11 12 College: 13 14 15 16 16+

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

WORK HISTORY

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

REFERENCES (Do not include relatives)

Full Name	Phone Number	Best Time of Day to Call	Relationship	Number 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 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 *Hands That Help PCA, 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**

Title of Position: Personal Care Worker

Title of Immediate Supervisor: Supervising Nurse

Duties of Position

- Provides personal care and related services in the home, assigned and under the direction, instruction and supervision of the Supervising Nurse. Tasks assigned must be ones that the PCW is specifically trained to perform
- Tasks to be performed by a PCW must be assigned by and performed under the supervision of an RN who will be responsible for the client/care services provided by the PCW.
- Under no circumstances may a PCW be assigned to receive or reduce any intravenous procedures, or any other sterile or invasive procedures, other than rectal temperatures or enemas.

Position Responsibilities

- Follows the plan of care to provide, safe, competent care/service to the client.
- Encourages the clients to become as independent as possible according the care plan.
- The Personal Care Worker shall be performed under the supervision of a registered nurse who meets the requirements of s. DHS 105.17 (3) and who is employed by or is under contract to a provider certified under s. DHS 105.17.
    1. Assistance with bathing
    2. Assistance with getting in and out of bed
    3. Teeth, mouth, denture and hair care
    4. Assistance with mobility and ambulation including use of walker, cane or crutches'
    5. Changing the client's bed and laundering the bed linens and the clients personal clothing
    6. Skin care excluding wound care
    7. Care of eyeglasses and hearing aids
    8. Assistance with dressing and undressing
    9. Toileting, including use and care of bedpan, urinal, commode, or toilet
    10. Light cleaning in essential areas of the homes used during personal care service activities
    11. Meal preparation; food purchasing and meal serving
    12. Simple transfers including bed to chair or wheelchair and reverse
    13. Accompanying the client to obtain medical diagnosis treatment
    14. Attempts to promote client's mental alertness through involvement in activities of interest
    15. Gives simple emotional and psychological support to the clients and other members of the household and establishes a relationship with client and family which transmit trust and confidentiality
    16. Reports any change in the clients mental or physical condition or in the home's situation to the supervisor
    17. Performs tasks assigned by the RN Supervisor
    18. Attends in-service as required by regulation
    19. Promptly report any changes observed or reported in the client's condition to the RN Supervisor

Title of Position: Personal Care Worker

Job Conditions

- The ability to drive and the ability to access client's homes which may not be routinely wheelchair accessible are required
- Hearing, eyesight, and physical dexterity must be sufficient to perform a physical assessment of the client's condition and to perform client care
- On occasion, may be required to bend, stoop, reach and move clients that weight up to 300 pounds: lift and/or carry up to 30 pounds
- Must be able to communicate clearly, both verbally and in writing

Company Information

- Has access to all client service records which may be discussed with the supervisor

Qualifications

- Preferably a high school diploma or equivalent
- Be trained under s. DHS 105.17 (1n) (a) 2. And (b) in the provision of personal care services; and in each skill that the personal care worker is assigned. Provide documentation of required training to the personal care provider for the providers records.
- Must be free from health problems that may be injurious to client, self and co-workers and must be present appropriate evidence to substantiate this.
- Bea person who is not a legally responsible relative of the client under the s. 49.90 (1) Stats.

Acknowledgement

Employee Signature: _____

Date:_____

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			**Additional Information**		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.		

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

BACKGROUND INFORMATION DISCLOSURE (BID)

- **PENALTY: Knowingly providing false information or omitting information may result in a forfeiture of up to $1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).**
- Completion of this form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- Refer to DQA form F-82064A, *BID Instructions*, for additional information.

Check the box that applies to you.

☐ Employee / Contractor (including new applicant)
☐ Household member (lives on premises, but is not a client)
☐ Applicant for a license, certification, or registration (including continuation or renewal)
☐ Other – Specify: _____

NOTE: If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064 and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Full Legal Name – *First*	*Middle*	*Last*

Position Title (Complete only if a prospective or current employee or contractor.)	Birth Date *(MM/dd/yyyy)*	Sex ☐ Male ☐ Female

Any Other Names By Which You Have Been Known (Including Maiden Name)

Race / Ethnicity (Check ONLY one.) ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Unknown	Social Security Number

Home Address	City	State	Zip Code

Business Name and Address – Employer or Care Provider (Entity)

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.
Note: The areas below that are designated for responses are expandable.

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
   You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.
   Yes ☐ No ☐

2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.
   You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.
   Yes ☐ No ☐

3. **IMPORTANT: Read before completing item 3.**
   Wis. Stat. § 48.981 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY. "All reports made under this section, notices provided under sub. (3) (bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential." Reports and records may be disclosed only to the persons identified in this section.

   ☐ **If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.**

   Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect?
   If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.
   Yes ☐ No ☐

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? Yes ☐ No ☐

   If **Yes**, explain, including when and where it happened.

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? Yes ☐ No ☐

   If **Yes**, explain, including when and where it happened.

6. Has any government or regulatory agency (other than the police) ever found that you **abused an elderly person**? Yes ☐ No ☐

   If **Yes**, explain, including when and where it happened.

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? Yes ☐ No ☐

   If **Yes**, explain, including credential name, limitations or restrictions, and time period.

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes ☐ No ☐

   If **Yes**, explain, including when and where it happened.

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? Yes ☐ No ☐

   If **Yes**, explain, including when and where it happened and the reason.

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? Yes ☐ No ☐

   If **Yes**, indicate the year of discharge: _____

   Attach a copy of your DD214, if you were discharged within the last three (3) years.

4. Have you resided outside of Wisconsin in the last three (3) years? Yes ☐ No ☐

   If **Yes**, list each state and the dates you resided there.

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? Yes ☐ No ☐

   If **Yes**, list each state and the dates you resided there.

6. Have you had a caregiver background check done within the last four (4) years? Yes ☐ No ☐

   If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe? Yes ☐ No ☐

   If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.

Read and initial the following statement.

_____ I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

Name – Person Completing This Form	Date Submitted

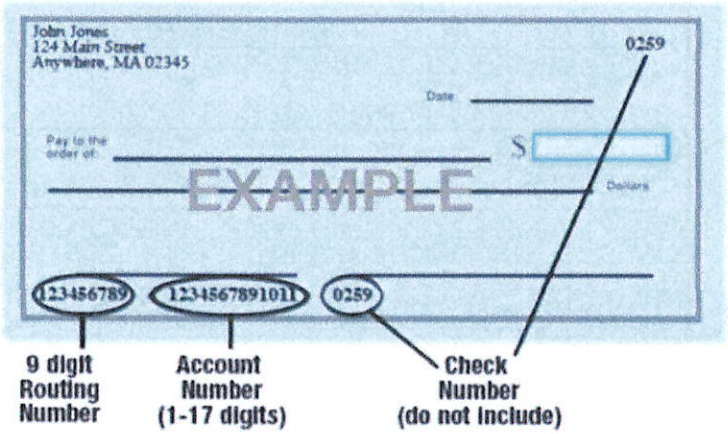
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ $ _____ ☐ _____% or ☐ Entire Paycheck

Type of Account: ☐ Checking ☐ Savings (Check One)

Attach a voided check for each bank account to which funds should be deposited (if necessary)

_____ [*Company Name*] is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee's Signature: _____

Date: _____