

Home & Health Care Services

Mailing Address: PO Box 250 | Hornell, NY 14843

Physical Address: City Hall 82 Main Street (3rd floor)| Hornell, NY 14843

(607) 324-4142

Fax: (607) 324-2378

Dear Applicant:

Please carefully complete the enclosed application. Be sure all addresses are complete for reference checks.

Please return with your application

Completed application
Signed reference request
Copy of your driver's license
Copy of your current auto insurance
Any proof of training
Auto Insurance Declaration page

If you have any, questions please contact our agency at (607) 324-4142

Please note that there are 2 sheets that require a notary signature

Please return your application to:

Director of Human Resources
Home & Health Care Services, Inc.
PO Box 250
Hornell, NY 14843

Thank you, for your interest in our agency. For tracking purposes how did you find out about our agency? _____

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APPLICATION FOR EMPLOYMENT

Please Print Clearly

Name: _____ Previous Names: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

RN___ Registry___ Supervisor___ License# _____ Exp. Date: _____

LPN___ Registry___ Supervisor___ License # _____ Exp. Date: _____

CNA___ HHA___ PCA___ HMKR___ Trainee___ Other _____

Highest Grade Completed – High School: _____ College _____

Other Training: _____ Where? _____

Graduation Date: _____ Currently Attending/Exp. Graduation Date: _____

PERSONAL REFERENCES *(Do not use relatives or previous employers.)*

Name: _____ Name: _____

Phone: _____ Phone: _____

Address: _____ Address: _____

Name: _____ Name: _____

Phone: _____ Phone: _____

Address: _____ Address: _____

1. Do you have a current NYS drivers license? YES or NO
2. Do you have a dependable and insured auto for work? YES or NO
3. Has your driver’s license ever been suspended or revoked? YES** or NO
4. Have you ever been convicted of a crime? YES** or NO

**Please explain: _____

The New York State Human Rights Law prohibits discrimination in employment because of age, sex, race, creed, color, national origin or disability. Home & Health Care Services complies with this law. I authorize this service to make inquiry of any of my former employers or references as to my experience, character, habits and reason for leaving employment. I understand also that receipt of satisfactory medical reports regarding me is required. I agree to abide by the rules of this service and to notify the service promptly of any change of address and/or telephone number. I certify that the above statements are true to the best of my knowledge and understand that the making of false statements will be considered sufficient cause for immediate discharge from employment.

Signature of Applicant: _____ Date: _____

PREVIOUS EMPLOYMENT RECORD *(Please begin with the current or most recent)*

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Business: _____

Dates Employed: _____

Mailing Address: _____

Phone: _____

ATTN: _____

Your position and duties: _____

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ATTN: _____

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Please comment on all personal experience you have had that relates to the position you are applying for with Home & Health Care Services:

Signature of Applicant: _____

Date: _____

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Signature of Applicant: _____ **Date:** _____

TO: Employment: _____ **Personal:** _____
Employer *Name*

The individual named above is applying for a position as a _____ and has given your name as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response. If you have any questions, please phone the agency office at 607-324-4142.

This is a **personal / employment** reference. (*circle one*)

Please answer the questions below, if applicable:

Position held or capacity known: _____

Dates employed or personally known: _____

Name while employed with your company: _____

4=Excellent 3=Good 2=Fair 1=Poor n/a=Does not apply

Quality of Work _____ Attendance _____ Cooperation _____ Integrity _____

Honest _____ Patient _____ Motivated _____

Knowledge & Skills _____ Professional Appearance _____

Additional Comments: _____

Dates Employed: From: _____ to _____

Would you re-hire? Yes__ No__ Comments: _____

Reason for leaving employment: _____

Completed by: _____ *Title* **Date:** _____

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NOTIFICATION TO PROSPECTIVE EMPLOYEE

RE: Criminal History Record Checks

Effective: 4/1/05

This is to inform you that the State Commissioner of Health now mandates all licensed home care agencies to obtain a criminal history record report for all prospective employees prior to their employment. This mandate protects the welfare and security of the vulnerable patients of nursing facilities and home care services agencies.

1. You will have the opportunity to obtain, review and explain the information obtained in the Criminal History Record Check.
2. You may withdraw your application for employment at any time, without prejudice, prior to Home & Health Care Services' decision to hire you. Upon such withdrawal, any fingerprints and criminal history records concerning you will be destroyed.

I _____ authorize Home & Health Care Services to submit a ten-point rolled fingerprint card and other identifying information to the Attorney General of the United States for a search of the criminal history records of the FBI.

Signature of Applicant

Date

Signature of Witness

Date

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INFORMATION RELEASE FORM

To be considered for employment with Home & Health Care Services, I authorize the release of all information about me from any of the following sources:

- Motor Vehicle Department
- Former Employees
- Federal Bureau of Investigation (FBI)
- Personal References
- Department of Social Services in the county I reside
- Sheriff Department in the county I reside
- Police in the town/city I reside
- New York State Police
- All police agencies from former places of residence

I, _____, understand that only the relevant information obtained through this investigation shall be considered for my potential employment with Home & Health Care Services. I understand I have the right to withdraw my application any time prior to being hired.

Other names/alias (maiden or married)

Driver's License Number & State

Social Security Number

Date of Birth

Signature in present of a Notary:

Signature of Applicant

Date

< Seal >

Signature of Notary

Date

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Authorization for Search and Exchange of Information

I, _____ hereby authorize Home & Health Care Services, Inc. to submit a request to the Attorney General of the United States to conduct a search of the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other information submitted by me. I further authorize the exchange of such information between the Attorney General of the United States, the New York State Department of Health and Home and Health Care Services, Inc. this information may be used only by Home and Health Care Services, Inc and only for the purpose of determining my suitability for employment in a position involved in direct patient care.

Signature: _____ Date: _____

Name: _____

Print

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Authorization for Motor Vehicle Report

My signature on this form authorized Home & Health Care Services to obtain a report of my motor vehicle record. This report may be used to evaluate my driving record and my eligibility for employment.

_____ I want a copy of the report.

_____ I do not want a copy of the report.

This report will be provided by: U.S. Investigative Services
4500 S. 129th E. Ave., Suite 200
Tulsa, OK 74134

Last Name: _____

First Name: _____

Middle Initial: _____

Date of Birth: ____/____/____

License Number: _____ Expiration Date: _____

Social Security Number _____

Signature: _____

Date of Authorization: ____/____/____