Application for Employment

We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law.

Applicant Name (last, first, middle): ______________________ Email Address: ______________

Present Address: ____

City/State/Zip: ____

Home Phone: ______________________________ Mobile Phone: ______________

Are You at Least 18 Years Old? ☐ Yes ☐ No

☐ Full Time ☐ Part Time Per Visit Shift: ☐ Day ☐ Night

Position Applying For: ____________________ ☐ Part Time ☐ Pool ☐ Evening ☐ W/E

If you are not a US Citizen, do you have the legal right to remain permanently in the US? ☐ Yes ☐ No

Salary Requirements: __________ Date Available: ________

Do you have adequate means of transportation to get to work on time each day and when called in on short notice during normal working hours? ☐ Yes ☐ No

____

____

Educational History

Type of School	Name & Location of School	Circle Last Year Attended	Graduated	Degree
High School		9 10 11 12		
College		1 2 3 4		
College		1 2 3 4		
Other		From: To:		

List professional licenses you possess. Indicate type of license, number and state:

____

____

Name _____

List any memberships in professional organizations, honors or activities which you feel would enhance your application, excluding those that would indicate race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law:

_____

_____

List languages spoken other than English:

_____

List other skills applicable to the position for which you are applying, including computer experience, typing speed, etc:

_____

_____

Work History

Attach an additional sheet listing other work experience pertinent to the position for which you are applying if the space below is insufficient:

Company Name	Complete Address including City/State/Zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business □ Full Time □ Part Time □ Per Visit	Reason For Leaving	OK to Contact Supervisor □ Yes □ No

Describe your job title, responsibilities and accomplishments:

Company Name	Complete Address including City/State/Zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business □ Full Time □ Part Time □ Per Visit	Reason For Leaving	OK to Contact Supervisor □ Yes □ No

Describe your job title, responsibilities and accomplishments:

Company Name	Complete Address including City/State/Zip	Phone Number	Supervisor's Name

Date Started Date Left	Type of Business □ Full Time □ Part Time □ Per Visit	Reason For Leaving	OK to Contact Supervisor □ Yes □ No

Describe your job title, responsibilities and accomplishments:

_____

_____

_____

_____

PERSONAL REFERENCES: (Name, Phone, Relationship) _____

_____

_____

_____

Emergency Contact	Relationship	Phone	Address
Out of state contact, if possible	Relationship	Phone	Address

Please review and sign
In making application for employment:

- I certify that the information in this application is true and complete for all practical purposes. It may be verified by the Agency or any affiliate. Should a position be offered and later it is found that the information is significantly untrue, incomplete, or misrepresented, I understand and agree that the Agency or its affiliates are relieved of all commitments, financial or otherwise pertinent to employment, and that I am subject to immediate discharge without recourse.

- I understand and agree that if I am offered employment by the Agency, my employment will be for no definite term and that either I, or the Agency will have the right to terminate the employment relationship at any time, with or without cause, and with or without notice. I also understand that this status can only be altered by a written contract of employment which is specific as to all material terms and is signed by me and the Administrator of the Agency.

- I understand, if I have direct patient contact that the Agency will perform a background check, including criminal history check, OIG exclusion list check (if applicable), and any additional checks as required by accrediting body standards or State Regulations. I further understand, if I am an unlicensed person, the Agency will perform a check of the Nurse Aide Registry and Employee Misconduct Registry. I understand that: 1) the purpose of the Employee Misconduct Registry is to ensure that unlicensed personnel who commit acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers are denied employment in HHS-regulated facilities and agencies; 2) the State of Texas maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by the Texas Health and Human Services (HHS) and they review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides and if there's a finding of an alleged act of abuse, neglect, or misappropriation, the nurse aide may request both an informal reconsideration and a formal hearing before the finding is placed on the registry; 3) All HHS-regulated facilities and agencies are required to check the Employee Misconduct Registry and Nurse Aide Registry before hire to determine if I am listed in either registry as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer and am, therefore, unemployable. I understand that a refusal to authorize the criminal background check may result in adverse employment action, such as rejection of the application or termination of employment.

Release: I hereby authorize any prior employers to provide such information concerning my employment with them as may be requested, and also authorize the Registrar/Placement Office of all educational institutions attended to release an official copy of my transcript and, if available, faculty appraisals. I also authorize any appropriate licensing board to release full information concerning my license status and my license history.

Applicant Signature: _____ Date: _____

FOR OFFICE USE ONLY	☐ Interview(s)	☐ References Checked	If Hired: Position: Salary:	 Start Date: FT/PT/Per Visit

EMPLOYEE ACKNOWLEDGMENT

Confidentiality: The Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the patients/clients according to 1996, Health Information Portability and Accountability Act (HIPAA). Due to the nature of our work, each employee will gain, directly or indirectly, sensitive and confidential information on patients/clients and staff members. The health care professional safeguards the patient's/client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient/client information, etc. This information should be shared only with those persons who, due to their position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If an employee is in doubt as to whether or not certain information may be shared, s/he should consult with his/her supervisor.

Drug Testing Policy: The Agency maintains a drug free workplace policy with regard to the possession, use, distribution and sale of drugs or alcohol. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession or use of a controlled substance or any alcoholic beverages while in the workplace or on Company paid time. Violation of this policy can result in disciplinary action, up to and including termination of employment. I acknowledge I have received a copy of the agency's policy on drug testing.

Harassment Policy: The Agency is committed to providing a work environment, that is free from all forms of discrimination and unlawful harassment including sexual harassment. This policy applies to all employees including management personnel. Sexual harassment is any unwelcome sexual advances either explicit or implicit as a term or condition of employment. Improper behavior may be verbal, visual, or physical in nature and/or the creation of a hostile environment. Management will investigate complaints of sexual harassment promptly, impartially and without fear of retaliation to the employee. An employee should report the alleged incident immediately and confidentially to the appropriate manager or Human Resources.

Non Solicitation/Illegal Remuneration: The Agency does not reimburse or provide incentives to physicians, durable equipment providers, family or other referral entities for patient/client referrals for home health services. Employees may not solicit patients/clients for the agency. Employees found in violation of this non-solicitation policy will be subject to discipline up to and including termination of employment.

Non-Discrimination: The Agency does not discriminate against employees based on race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law. The employee may file a report of a grievance or complaint regarding discrimination with the Office of Civil Rights within 180 days of when the employee knew of the situation.

Non-Discrimination: The Agency does not discriminate in patient/client provision of services with respect to race, color, national origin, age, sex, disability, marital status, religion, or source of payment according to Title VI of the Civil Rights Act.

Abuse, Neglect, and Exploitation: Agency employees will report suspected abuse, neglect and/or exploitation to the Texas Department of Family and Protective Services, Texas Health and Human Services, and Agency management. Agency employees suspected of abuse, neglect, or exploitation will be suspended immediately, an investigation will be conducted, and if the investigation validates the claim, the employee will be terminated.

Workers' Compensation
The Agency is a subscriber to workers' compensation insurance. An employee who incurs an injury on the job that requires emergency medical treatment or is life threatening should proceed to the nearest emergency room. Emergency medical treatment (non life threatening) or non-emergency treatment should be referred to the agency's designated clinic. Notify the agency of an injury within 24 hours to complete paperwork. Medical expenses for injuries are covered with the exception of the following: employee's willful intent to hurt self or others, intoxication or drug use, horseplay, acts of God, and/or acts of a third party.

Progressive Discipline Policy: Agency utilizes a progressive discipline process in cases of misconduct or unacceptable performance. This includes verbal warning, written warning and final warning. Disciplinary action may begin at an advanced stage of the process or may result in immediate termination based upon the nature and severity of the offense, employee's past record and other circumstances.

Agency Policies: I acknowledge that I have read, understand, and will comply with all applicable agency policies and guidelines.

Employee:_____ **Date**:_____

Reference Request

Date: _____ Check method of gathering reference data: ☐ Verbal ☐ Mail

Name of person giving reference: _____ Facility: _____

The individual named below is applying for a position as _____ and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance _____
(Name of Company Representative)

Applicant Release

Applicant _____ _____
Last First MI Maiden

Position Held _____

Social Security # _____ Dates Employed: From _____ To _____

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

_____ _____
Applicant Signature Date

1) Please confirm the applicant's employment. From _____ To _____
Date Date

2) Please comment on the applicant's attributes using the following scale:
4 = Excellent 3 = Good 2 = Fair 1 = Poor N/A = Not applicable

Quality of Work _____

Knowledge & Skills _____

Reliability & Attendance _____

Cooperation _____

Competence _____

Supervisory ability & capacity _____

Grooming _____

3) Please indicate specialty areas in which the applicant has had experience: _____

_____

4) Please indicate any special considerations necessary when giving assignments to this individual:

_____

5) Is applicant eligible for rehire? ☐ Yes ☐ No If no, why not? _____

_____

Please attach any additional comments.

_____ _____ _____
Signature Position/Title Date

HCL / Reference Check
Org. 110100

Reference Request

Date: _____ Check method of gathering reference data: □ Verbal □ Mail

Name of person giving reference: _____ Facility: _____

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Position Held _____

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Grooming _____

3) Please indicate specialty areas in which the applicant has had experience: _____

_____

4) Please indicate any special considerations necessary when giving assignments to this individual:

_____

5) Is applicant eligible for rehire? □ Yes □ No If no, why not? _____

_____

Please attach any additional comments.

_____ _____ _____
Signature Position/Title Date

HCL / Reference Check
Org. 110100

STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by the Agency and agree that the Agency may conduct a State of Texas criminal history check per TXH&SC 250.006. I agree to a search of the Nurse Aide Registry and the Employee Misconduct Registry prior to employment and at least every 12 months if hired. As required, I agree to a search of the Texas Health and Human Services Commission's OIG List of Excluded Individual/Entities and the HHS - OIG Excluded Individuals/Entities Search Database prior to being hired and monthly thereafter. I understand that these checks will determine if I have a criminal conviction or have committed certain conduct that will bar me from employment with this Agency. I understand that I am unemployable if listed as unemployable in the NAR or EMR per TAC §93.3 and TxH&SC Chapter 253.

CRIMINAL HISTORY CHECK

I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that my employment is pending the results of the criminal history check and that I may not have face-to-face patient/client contact until results are returned. I will be notified of results.

CONVICTIONS BARRING EMPLOYMENT.

(A) A person for whom the facility is entitled to obtain criminal history record information may not be employed in a facility if the person has been convicted of an offense listed in this subsection:

- An offense under Chapter 19, Penal Code (criminal homicide);
- An offense under Chapter 20, Penal Code (kidnaping, unlawful restraint, and smuggling of persons);
- An offense under Section 21.02, Penal Code (continuous sexual abuse of a young child or children) or Section 21.11, Penal Code (indecency with a child);
- An offense under Section 22.011, Penal Code (sexual assault);
- An offense under Section 22.02, Penal Code (aggravated assault);
- An offense under Section 22.04, Penal Code (injury to a child, elderly individual, or disabled individual);
- An offense under Section 22.041, Penal Code (abandoning or endangering a child);
- An offense under Section 22.08, Penal Code (aiding suicide);
- An offense under Section 25.031, Penal Code (agreement to abduct from custody);
- An offense under Section 25.08, Penal Code (sale or purchase of a child);
- An offense under Section 28.02, Penal Code (arson);
- An offense under Section 29.02, Penal Code (robbery);
- An offense under Section 29.03, Penal Code (aggravated robbery);
- An offense under Section 21.08, Penal Code (indecent exposure);
- An offense under Section 21.12, Penal Code (improper relationship between educator and student);
- An offense under Section 21.15, Penal Code (improper photography or visual recording);
- An offense under Section 22.05, Penal Code (deadly conduct);
- An offense under Section 22.021, Penal Code (aggravated sexual assault);
- An offense under Section 22.07, Penal Code (terroristic threat);
- An offense under Section 32.53 Penal Code (exploitation of a child, elderly individual, or disabled individual);
- An offense under Section 33.021, Penal Code (online solicitation of a minor);
- An offense under Section 34.02, Penal Code (money laundering);
- An offense under Section 35A.02, Penal Code (Medicaid fraud);
- An offense under Section 36.06, Penal Code (obstruction or retaliation);
- An offense under Section 42.09, Penal Code (cruelty to livestock animals), or under Section 42.092, Penal Code (cruelty to nonlivestock animals); or
- A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection.

- An offense the Agency determines to be contraindicated to employment with the consumers the Agency serves.

(B) A person may not be employed in a position the duties of which involve direct contact with a patient/client in a facility or may not be employed by an individual employer before the fifth anniversary of the date the person is convicted of:

- An offense under Section 22.01, Penal Code (assault), that is punishable as a Class A misdemeanor or as a felony);
- An offense under Section 30.02, Penal Code (burglary);
- An offense under Chapter 31, Penal Code (theft) that is punishable as a felony);
- An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or a felony; or
- An offense under Section 32.46, Penal Code (securing execution of a document by deception) that is punishable as a Class A misdemeanor or a felony.
- An offense under Section 37.12, Penal Code (false identification as a peace officer; misrepresentation of property); or
- An offense under Section 42.01 (a) (7), (8), or (9), Penal Code (disorderly conduct).

(C) In addition to the prohibitions on employment prescribed by Subsections (A) and (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:

- Of an offense under Section 30.02, Penal Code (burglary); or
- Under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.

(D) For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with, Article 42A.111 Code of Criminal Procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment. I understand that all information obtained by this Agency regarding any criminal history will remain confidential.

I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

_____ _____

Signature of Applicant Date

For Agency Use Only: Criminal History, Employee Misconduct Registry (EMR), Nurse Aide Registry (NAR), and OIG Exclusion Lists checks completed:

❑ Criminal History Check completed on-line ❑ Other Convictions identified on Criminal History. (Document the reason for hiring in Comments below.)

❑ NAR ❑ EMR checked online at https://emr.dads.state.tx.us/DadsEMRWeb/

❑ OIG Exclusion Lists checked at https://oig.hhsc.state.tx.us/Exclusions/Search.aspx and http://www.oig.hhs.gov/fraud/exclusions.asp

❑ Applicant employable ❑ Applicant not employable ❑ Comments: _____

_____

_____ _____

Verified By Date

TB FACT SHEET/RISK AND SYMPTOM SCREEN

Tuberculosis (TB)

Mycobacterium Tuberculosis is transmitted by air, carried in droplets that are created when a person with respiratory TB coughs, sneezes or shouts. TB Infection occurs when someone inhales the droplet particles containing the Mycobacterium. A person may have no symptoms, but still have latent TB infection (LTBI) and may develop TB disease at some point in their lives. TB skin tests may become positive in 2 to 12 weeks after the exposure.

Risk Factors

Check if any of the following risk factors apply to you:

Groups with a higher risk of exposure and infection*

- ❒ Low income/medically under served populations
- ❒ Residents or employees of congregate living facilities such as homeless shelters, long-term care facilities and correctional facilities
- ❒ Infants, children or adolescents who are exposed to adults in high-risk categories
- ❒ Foreign-born persons recently arrived (within 5 years) from areas with a high incidence of TB, such as Asia, Africa, Eastern Europe, Latin America and Russia, or those who frequently travel to areas with a high incidence of TB
- ❒ Close contacts with individuals with pulmonary TB persons who inject illicit drugs or other locally identified high-risk substance users (e.g., crack cocaine users)

*Flexibility is needed in defining local high-priority groups for screening

Groups with a greater risk to progress from latent TB infection to active disease

- ❒ Individuals with HIV infection, silicosis, diabetes, chronic renal failure, and those more than 10% below normal body weight, hematologic disorders (e.g., leukemias and lymphomas), other specific malignancies (e.g., carcinoma of the head or neck),
- ❒ Those receiving some medical treatments that may increase risks, such as prolonged corticosteroid use, or other immunosuppressive treatments, bone marrow or organ transplant, intestinal bypass or gastrectomy
- ❒ Persons with a history of untreated or inadequately treated TB disease

Signs and Symptoms of TB Disease in the Lungs*

Check if you currently have any of the following symptoms:

- ❒ Sweating at night
- ❒ Weight loss
- ❒ No appetite
- ❒ A bad cough lasting more than three weeks
- ❒ Coughing up blood or sputum (phlegm from deep inside the lungs)
- ❒ Chills
- ❒ Fever
- ❒ Weakness or Fatigue
- ❒ Chest pain

*Symptoms of TB disease in other parts of the body depend on the area affected.

- ❒ I am not experiencing any of the above symptoms
- ❒ None of the above risk factors apply to me.

I understand if I am experiencing any of the above symptoms, followup will be required. I understand if I have any of the above symptoms at any time in the future, I am to report to management immediately and follow-up will be required at that time.

Signature _____ Date _____

HEPATITIS B VACCINATION

Due to your occupational exposure to blood or other potentially infectious materials, you may be at risk for acquiring hepatitis B viral (HBV) infection. The vaccination series is available, at no cost, to you. Please indicate below your declination or acceptance to receive the vaccine.

Hepatitis B is a blood borne virus which can cause a range of symptoms from mild to serious, and possibly result in fatal liver damage to health care workers who become infected. The virus can be transmitted through contact with infectious fluids of a client who has hepatitis B virus. You have been taught the concepts of Universal Precautions concerning safe client care and the use of equipment to avoid unnecessary exposure.

Synthetic hepatitis B vaccine is derived from yeast cells. It is not composed of human blood or plasma. It is given as a series of three injections into the arm muscle at prescribed intervals (initial shot, one month later, and six months later). It has proven to be over 80-90% effective in protecting against the disease. There may be hypersensitivity to the vaccine, and there may be soreness and swelling of the injection arm. Other side effects may occur at an incidence of under 3% of injections.

The vaccine will not be given to persons with known sensitivity to aluminum hydroxide, thimerosal, yeast or hepatitis antigen and will only be given with your personal physician's recommendations in the cases of pregnancy or presence of other infection of immunosuppressive state. The vaccine does not grant 100% assurance of immunity.

Acceptance: I have read the above information describing the risks and benefits of receiving the vaccination. I understand that the decision to receive the vaccination series is mine and I wish to receive the hepatitis B vaccine.

Employee Signature	Date	Witness

Declination: ☐ I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. I decline the vaccination series. I understand that by declining this vaccine, I continue to be at risk for acquiring hepatitis B. If I continue to have occupational exposure to blood or other potentially infectious material (OPIM) and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

☐ I have already received the hepatitis vaccine at an earlier date. I am ☐ am not ☐ providing a copy of the record to the agency

Employee Signature	Date	Witness

CONFIDENTIALITY/CONFLICT OF INTEREST DISCLOSURE STATEMENT

CONFIDENTIALITY/NON-DISCLOSURE OF COMPANY OR PATIENT/CLIENT INFORMATION:

The Health Information Portability and Accountability Act (HIPAA) ensures the patient's/client's right to privacy of Protected Health Information to be maintained at all times. Any information related to the care of patients/clients through this Agency will be held as confidential. All information, written or verbal, will be disclosed only to appropriate health care personnel, appropriate staff, those with a "need to know basis", or to individuals the patient/client requests.

CONFLICT OF INTEREST DISCLOSURE STATEMENT:

I acknowledge I have read the policy and procedure regarding conflict of interest and the procedure for disclosure. I understand that if I have an outside relationship that is personal, professional, or otherwise, with a patient/client, vendor, or potential business associate, I must disclose the nature of that relationship to my supervisor, or Administrator as soon as the relationship is established. I also understand that I forfeit any voting privileges, decision making capacity, and input from any activities associated with said relationship.

I,_____ as an employee or member of the Governing Body, am providing the following disclosure as potential conflict of interest:

_____

_____

_____

_____

_____

❑ I have no conflict of interest to report

_____ _____ _____

Name (Please Print) Signature Date

Reported conflict of interest reviewed by the Governing Body with clearance provided.

_____ _____

Signature of Governing Body Member(s) providing clearance Date