

# Hope, Care & Love Home Healthcare Agency

## Application for Employment

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Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State/Province ZIP/Postal Code

SSN: \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_\_

Cell Phone Carrier: \_\_\_\_\_

E-Mail address \_\_\_\_\_ Referred to us by \_\_\_\_\_

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Position(s) applied for Caregiver Nursing Other: \_\_\_\_\_ Date available. \_\_\_\_\_

Type of employment desired Full-Time  
Part-Time  
On-Call  
Live-In Shift

**Please Specify Days and Hours you are available:**

SUN	MON	TUE	WED	THU	FRI	SAT

If currently employed, may we contact your employer? Yes No

Rate of Pay Expected \$ \_\_\_\_\_ per hour

Is there a specific reason you are applying for employment at this company? Yes No

If Yes, please briefly outline the reason:

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Are you legally eligible for employment in this country? Yes No

Are you available to work overtime if required? Yes No

Have you applied with this company before? Yes No

Do you have any friends or family employed at this location? Yes No Who: \_\_\_\_\_

Have you been convicted of a crime in the last seven (7) years? Yes No

If yes, please explain \_\_\_\_\_

CONVICTION WILL NOT NECESSARILY BE A DISQUALIFICATION FOR EMPLOYMENT.

If considered for hiring, will you give consent to provide a criminal background check? Yes No

If considered for hiring, will you agree to provide a driver's motor vehicle check? Yes No

### EDUCATIONAL BACKGROUND

# Hope, Care & Love Home Healthcare Agency

List previous three (2) educational institutions attended, beginning with the most recent.

SCHOOL	CITY, STATE/PROVINCE	GRADUATED?	DEGREE(S)/DIPLOMA(S) EARNED
		Yes No	
		Yes No	

What Nursing or relevant designations, licenses, or registrations if any, do you possess?

Type	Date of Most Recent Registration	Valid in State of Virginia
_____	_____	Yes No
_____	_____	Yes No

Do you have the following:

CNA / HHA / MA	No	Yes	Last Certified _____
CPR / First Aid	No	Yes	Last Certified _____
TB	No	Yes	Last Certified _____

Please indicate other professional licenses and certifications: \_\_\_\_\_

## EMPLOYMENT BACKGROUND

Provide the following information beginning with the most recent employer.

EMPLOYER	TELEPHONE (   )	DATES EMPLOYED		
		FROM	TO	
ADDRESS				
JOB TITLE		HOURLY RATE/ SALARY		
		STARTING		
IMMEDIATE SUPERVISOR AND TITLE AND PHONE NUMBER		\$	per	
REASON FOR LEAVING		HOURLY RATE/ SALARY		
		FINAL		
MAY WE CONTACT FOR REFERENCE?		\$	per	
Yes   No   Later				
EMPLOYER	TELEPHONE	DATES EMPLOYED		

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	FROM	TO	
ADDRESS			
JOB TITLE	HOURLY RATE/ SALARY		
	STARTING		
IMMEDIATE SUPERVISOR AND TITLE AND PHONE NUMBER	\$	per	
REASON FOR LEAVING	HOURLY RATE/ SALARY		
	FINAL		
MAY WE CONTACT FOR REFERENCE?  Yes    No    Later	\$	per	
EMPLOYER	TELEPHONE	DATES EMPLOYED	
	(    )	FROM	TO
ADDRESS			
JOB TITLE	HOURLY RATE/ SALARY		
	STARTING		
IMMEDIATE SUPERVISOR AND TITLE AND PHONE NUMBER	\$	per	
REASON FOR LEAVING	HOURLY RATE/ SALARY		
	FINAL		
MAY WE CONTACT FOR REFERENCE?  Yes    No    Later	\$	per	

*I certify that all the information I have provided is true, complete, and correct.*

*The information contained within this application or any cover letter or resume attached is not shared with any third parties. The information is used by the employer only as an aid in the hiring decision making process. The applicant, by signing the application gives the employer consent to collect the information contained herein and use for the purpose specified.*

# Hope, Care & Love Home Healthcare Agency

Please list any other LEGAL names you may be known by. (Example: Married before, Maiden Name, etc.)

Other Legal Names Used \_\_\_\_\_

Social Security Number \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Birth \_\_\_\_\_

Driver's License # \_\_\_\_\_ State \_\_\_\_\_

## Current Address

Street Address \_\_\_\_\_

City and Zip Code \_\_\_\_\_

How long have you been at your present address? \_\_\_\_\_

## Prior Address

Street Address \_\_\_\_\_

City and Zip Code \_\_\_\_\_

List other States you have lived in within the past 10 years: \_\_\_\_\_

\_\_\_\_\_

## Hope, Care & Love Home Healthcare

### **EMPLOYMENT PROFESSIONAL REFERENCE CHECK FORM**

Name of Applicant	
Reference Name	
Reference phone number, fax or email	
Company or Relationship	

*For Office Use Only*

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 \_\_\_\_\_ Has applied for employment with Hope, Care, & Love. We would like to verify information that we received from this candidate regarding his/her employment with you.

Start & End Date of employment with your organization: Start: \_\_\_\_\_  
 End: \_\_\_\_\_

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

Position held within your origination \_\_\_\_\_

Duties performed while employed \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	Poor	Good	Very Good	Excellent
Attendance				
Productivity				
Quality of work				
Initiative				
Reliability				
Special Skills				

\_\_\_\_\_  
 Employer Signature/Title

\_\_\_\_\_  
 Date

# Hope, Care & Love Home Healthcare Agency

## DISCLOSURE/RELEASE/AUTHORIZATION FORM

1. By this document *Hope, Care & Love Home Healthcare Services* is hereinafter referred to as the Agency, discloses to you that a consumer report may be obtained for employment purposes as part of the pre-screening background check and at any time during your employment or affiliation.

2. This shall authorize the procurement of a consumer report by a credit reporting agency or other sources as part of the pre-screening background investigation. If accepted, this authorization shall remain on file and shall serve as an ongoing authorization for the named employer or its associates or other sources to procure consumer reports at any time during my affiliation or employment period.

3. I also authorize the procurement of an investigative consumer report and understand that it may contain information about my employment and educational background, professional licenses and certifications, criminal history, credit, workers comp claims, mode of living, character and personal reputation. I also understand you may make use of the internet including social networking sites. I understand that I have the right to obtain additional disclosure as to the nature and scope of the investigation upon written request within a reasonable period of time and to obtain a copy of the report upon request. This authorization, in original or copy form, shall be valid for this and any future reports or updates that may be requested.

4. In connection with this request, I authorize all corporations, companies, former employers, supervisors, credit agencies, educational institutions, law enforcement/criminal justice agencies, city, state, county and federal courts, state motor vehicle bureaus and persons to release information they may have about me to the person or company with which this form has been filed if required, or their agent. I further authorize you to secure an investigative consumer report at any time, and any number of times, before, during and after my employment, if in the company's (or its designees) discretion, it has a legally permissible and legitimate business need for the information requested.

5. I release and hold harmless all parties involved from any and all liability for damages arising from requesting, procuring or furnishing the requested information except with respect to a violation of the Act. I authorize the employer and its agent/credit reporting agency and all associated entities and its clients to receive any criminal history information or credit report pertaining to me in the files of any state or local criminal justice agency.

6. Section 32.1-162.9:1 of the Code of Virginia requires home care providers, as defined in §32.1-162.7 of the Code of Virginia, to obtain a criminal record report on applicants for compensated employment from the Virginia Department of State Police. Section 32.1-162.9:1 of the Code of Virginia also requires that all applicants for employment in home care organizations provide a sworn disclosure statement regarding their criminal history.

My signature below also indicates that I have received a Summary of Rights in accordance with the Fair Credit Reporting Act.

Applicant's Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_

# Hope, Care & Love Home Healthcare

## WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY SICWC 00 00 08 NOTICE TO EMPLOYER

RE: Post-Accident Drug and Alcohol Policy:

Stonewood Insurance Company (Stonewood) requires all policyholders to implement a post-accident drug and alcohol testing policy. This policy is in accordance with Chapter 65.2, Section 306 of the Code of Virginia which states that:

"no compensation shall be awarded to the employee or his dependents for an injury or death caused by:

1. The employee's willful misconduct or intentional self-inflicted injury.
2. The employee's attempt to injure another.
3. The employee's intoxication.
4. The employee's willful failure or refusal to use a safety appliance or perform a duty required by statute.
5. The employee's willful breach of any reasonable rule or regulation adopted by the employer and brought, prior to the accident, to the knowledge of the employee; or
6. The employee's use of a non-prescribed controlled substance identified as such in Chapter 34 (54.1-3400 et seq.) of Title 54.1

A drug and alcohol test will be required after each work-related injury requiring medical treatment. The test will be performed at the time medical treatment is first administered and the cost of the test will be covered by Stonewood as a reasonable claims expense for all reportable workers' compensation claims. For any questions by the treating physician or employer regarding the administering of such a test, please call the Stonewood Claims Department at 1- 800-780-7454.

## WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY SICWC 00 00 09 ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge receipt of the Policy of Stonewood Insurance Company (Company) regarding post-accident drug and alcohol testing. I have read and understand the Policy requiring a drug and alcohol test to be conducted on all employees involved in work-related accidents. I understand that if I test positive for drugs or alcohol or refuse to submit to any drug and/or alcohol test required by this policy, I may be ineligible for workers' compensation benefits according to Chapter 65.2, section 306 of the Code of Virginia. Furthermore, I authorize the release of the test results to my employer and the Company's workers' compensation carrier. I recognize that the Company's policy on drugs and alcohol does not constitute an express or implied contract of employment.

Employee Name (print) \_\_\_\_\_

Employee Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

Employer Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

# Hope, Care & Love Home Healthcare Agency

*I authorize the employer to investigate all statements contained on this application. I understand that any misrepresentation or omission of facts called for is cause for immediate disqualification and/or if employed, immediate dismissal.*

*I understand that if I am hired, I will be required to provide criminal background check, proof of identity and legal authority to work in Virginia, proof of certifications or educational qualifications, and a driver abstract (if applicable). Additionally, I give Hope, Care & Love Healthcare Services permission to take **\$20.00** dollars out of my first paycheck for my criminal background check.*

*Furthermore, I understand and agree that if employed, I am free to resign at any time, with or without cause and without prior notice, and the employer reserves the same rights to terminate my employment at any time, with or without prior notice, except as may be required by law. This application does not in any way constitute an agreement or contract for employment.*

**Applicant's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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For office use only:

Date application received: \_\_\_\_\_  
Date applicant contacted: \_\_\_\_\_  
Date applicant hired: \_\_\_\_\_