EMPLOYMENT ACKNOWLEDGEMENT

TODAY'S DATE:_____

NAME:_____
Last First M.I.

OTHER NAMES KNOWN BY:_____

SOCIAL SECURITY NO: XXX-XX *(last four Digits)*

APPLICANT NOTICE

The Texas Department of Aging and Disability Services Code Chapter 106 requires this facility to obtain Criminal History Checks on individuals who are Not Credentialed, Registered or Licensed and are employed in a position of which the duties involve some contact with a consumer of services provided by this agency.

Please answer the following question:

Have you ever been convicted of a felony? ☐ No ☐ Yes If yes, Please explain:_____

_____

Have you ever been convicted of a misdemeanor or been on probation or deferred adjudication for or are you now awaiting trial for, on probation for, or on deferred adjudication?

☐ No ☐ Yes If yes, Please explain: _____

_____

Convictions will not necessarily disqualify an applicant from employment. All factors and circumstances will be considered for all or any convictions.

_____
Applicant Signature

APPLICANT NOTICE

Effective January 01, 2002 under SB 1245, Texas Department of Aging and Disability Services (DADS) Code Chapter 253, Health and Safety Code, now includes Home and Community Support Services Agencies (HCSSA) home health aides in the Employee Misconduct Registry (EMR). This facility is required to obtain verification checks prior to employment on individuals who are uncredentialed or unlicensed employees who provide the following services to residents, consumers, or individuals receiving services in Texas Department of Aging and Disability Services regulated facilities or agencies:

- Direct care services;
- Personal care services;
- Active treatment; and
- Any other personal services

PURPOSE

The Employee Misconduct Registry (EMR) was implemented to tract acts of reportable conduct committed against facility residents/consumers, or individuals receiving agency services by unlicensed employees. Reportable conduct includes:

- Abuse or neglect that may cause death or harm to an individual
- Sexual abuse of an individual;
- Financial exploitation of an individual in an amount of $25.00 or more; and
- Emotional, verbal, or psychological abuse that causes harm to an individual.

All DADS regulated facilities and agencies are also required to:

- Deny employment to any person who is listed on the registry as unemployable; and
- Provide written notification to all employees about the **EMR.**
- All incident reports against unlicensed employees (home health aides) will be made or sent to **The Texas Department of Aging and Disabilities Services Consumer Rights and Services Hotline at 1-800-228-1570**; and
- To the **Texas Department of Protective and Regulatory Services (PRS)** (for acts of abuse, neglect or exploitation against a client) at 1-800-252-5400.

Only acts of misconduct that occur on or after January 01, 2002 will be recorded in the Employee Misconduct Registry (EMR).

Only when all due process considerations by DADS and PRS are exhausted, is the individuals name listed on the registry as unemployable.

_____ _____

Applicant Signature Date

APPLICATION FOR EMPLOYMENT *CONFIDENTIAL*

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

We do not discriminate on the basis of race, religion, color, creed, gender, sex, age, national origin, marital, disability or veteran status or any other legally protected status. We are an at-will employer, any applicant accepted for employment can be terminated with or without notice.

PLEASE PRINT

Date of Application:	XXX-XX *(last four Digits)*	Position(s) Applied for:

Last Name:	First Name:	Middle (if any)

List any other names used if different from name given on this application:

Address	City	State	Zip Code

Telephone Number(s):
Home _____ What time may we call this number? _____
Work _____ When are you available at this number? _____
Pager _____ Other telephone numbers where we may contact you:
Cellular _____ _____

General Information

Are you at least 18 years of age? ☐ Yes ☐ No

Have you ever filed an application with us before? ☐ Yes ☐ No
If yes, give date _____

Have you ever been employed with us before? ☐ Yes ☐ No
If yes, give date _____

Do you have any friends or relatives, other than a spouse who, work for DEDICATION OF CARE HOME HEALTH AGENCY ? ☐ Yes ☐ No
If yes, state name, relationship and location _____

Are you currently employed? ☐ Yes ☐ No

May we contact your present employer? ☐ Yes ☐ No

Are you prevented from lawfully becoming employed in this country because of Visa or Immigration status? ☐ Yes ☐ No
Proof of citizenship or immigration status will be required upon employment

Date available for work _____/_____/_____

Are you available to work: ☐ Full Time ☐ Part Time ☐ Temporary ☐ Per Visit/ PRN ☐ Contract

Shifts: ☐ Any Shifts ☐ Days Only ☐ Evenings/Nights Only ☐ Weekends Only ☐ On Call Rotation

Are you willing to travel if a job requires it? ☐ Yes ☐ No If yes, what percent of the time? _____
How did you learn about us? ☐ Newspaper Ad ☐ Came in on my own ☐ School ☐ Agency Employee ☐ Other: _____

EDUCATION

School	Name and Address of School	Course of Study	Years Completed	Diploma/Degree
High School				
Undergraduate College				
Graduate/Professional				
Other (Specify)				

Work Experience

List all previous employment, start with the most recent/current job, include all contract and Per Diem work.

Employer	**Dates of Employment**	**Work Performed**
Address, City, State, Zip	From:	
Telephone Number(s)	To:	
Job Title	HOURLY RATE/SALARY	
Supervisor	Starting:	
Reason for Leaving	Final:	May we contact? ☐ Yes ☐ No

Employer	**Dates of Employment**	**Work Performed**
Address, City, State, Zip	From:	
Telephone Number(s)	To:	
Job Title	HOURLY RATE/SALARY	
Supervisor	Starting:	
Reason for Leaving	Final:	May we contact? ☐ Yes ☐ No

Employer	**Dates of Employment**	**Work Performed**
Address, City, State, Zip	From:	
Telephone Number(s)	To:	
Job Title	HOURLY RATE/SALARY	
Supervisor	Starting:	
Reason for Leaving	Final:	May we contact? ☐ Yes ☐ No

Comments: Include explanation of any gap(s) in employment ____

IF A CERTIFICATE, LICENSE OR OTHER AUTHORIZATION IS REQUIRED OR RELATED TO THE POSITION FOR WHICH YOU ARE APPLYING, COMPLETE THE FOLLOWING: (Proof of any of the following will be required upon employment.)

License/Certification (RN, LVN, PT,OT, ST, CNA, etc.)	Date Issued	Issued by (State or other authority)	License No.

OTHER SKILLS/CERTIFCATION/SPECIALTIES (Proof of any certification(s) will be required upon employment)

☐ CPR ☐ IV Therapy ☐ Neonatology/Newborn ☐ Adults _____

☐ BCLS ☐ PICC Lines ☐ Chemo ☐ MD office/Clinic

☐ ACLS/PALS ☐ Pediatrics ☐ Enterostomal Therapy ☐ Other _____

List all special skills you posses and machines or office equipment you can use, such as calculators, printing or graphics equipment, computer equipment, types of software and hardware, etc.

_____
_____
_____

Are you bilingual? _____ If "Yes", which language do you speak? _____

Additional Information

Other Qualifications – Summarize special job-related skills and qualifications acquired from employment or other experience.

_____
_____
_____

Personal/Professional References

Name	Phone Number	Best Time to Call	Occupation
1.			
2.			

NOTIFICATION IN CASE OF EMERGENCY

If employed, whom shall we call in case of emergency?

Name _____ Home Phone _____ Relationship _____

Address _____ City/State/Zip _____ Other No. _____

EMPLOYEE ACKNOWLEDGEMENT AND RELEASE OF INFORMATION

Please read and acknowledge the information below before you sign the application.

1. I hereby declare that I have accounted for all of my work experience, and training, and to the best of my knowledge, all the information I have provided on this application is true, complete and accurate. I understand that any false information or omission of information on this and other employment information will be sufficient reason not to consider me for employment or terminate me immediately if the same is discovered after employment with this company.

2. I understand that as a part of the procedure for processing this application, DEDICATION OF CARE HOME HEALTH AGENCY may check all the references listed, including both work related and personal. I hereby authorize personnel from my past employers, my personal references, and persons inquired about me, to release any information and previous employee evaluations about my work skills, work habits, ability, personal character and reputation. I release them from any and all liability for doing so. I acknowledge that I will not hold Dedication of Care Home Health Agency. liable in any capacity for the release of the information.

3. I understand that pursuant to Human Resource Code, Title 6, Chapter 106, and the rules adopted by the State of Texas Department of Aging and Disability Services under 40 TAC 75.1001 et. Seq., may conduct a Criminal History Check for individuals seeking employment in a position whose duties will/could involve direct contact with a consumer of home health services. I hereby release DEDICATION OF CARE HOME HEALTH AGENCY from any and all potential liability resulting from the investigation and any release of information learned during this process, including any damage of my reputation. I also understand that my driving of company owned or leased vehicles. I further understand that I may not be hired if either of these checks results in unfavorable information and understand that I may be terminated immediately after subsequent checks reveal any unfavorable information.

4. I understand and agree that, if I am offered employment with DEDICATION OF CARE HOME HEALTH AGENCY that I will be an "at will" employee only. I understand that this means that if employed, such employment is for an indefinite period and is subject to be terminated, changed, change in wages, conditions of employment, benefits, and operating policies with or without cause and with or without any prior notice. I understand that no contract of any kind is being offered. Furthermore, I understand that no company representative, other than the Administrator (and in writing) has the authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the foregoing. This period, and all condition of employment, including benefits and compensation, may be changed or terminated at any time, for any reason, with or without cause by either myself, or by DEDICATION OF CARE HOME HEALTH AGENCY. No statements made in pre-hire interviews or discussion, nor statements made in recruitment materials or any kind, personnel handbooks, subsequent policies and procedures, policy manuals, or other company communications are never to be construed as altering the at-will nature of my employment with DEDICATION OF CARE HOME HEALTH AGENCY.

5. I understand that DEDICATION OF CARE HOME HEALTH AGENCY does not have Workers Compensation Insurance coverage to protect its' employees from damages due to work related illness or injury.

6. I have been advised that DEDICATION OF CARE HOME HEALTH AGENCY is a Smoke Free Workplace. Employees may not smoke or use smokeless tobacco products in any DEDICATION OF CARE HOME HEALTH AGENCY buildings, company vehicles, patients home, or other designated areas. Furthermore, I understand that DEDICATION OF CARE HOME HEALTH AGENCY is also a Drug Free Company and therefore agree to take a drug and/or alcohol screen at ANY TIME while employed in any capacity by DEDICATION OF CARE HOME HEALTH AGENCY. I understand I will be terminated if the results of the screen are positive.

I HAVE READ ALL OF THE ABOVE INFORMATION VERY CAREFULLY, I FULLY UNDERSTAND THAT BY SIGNING MY NAME BELOW, I AM AGREEING TO THE TERMS OF ALL THESE STATEMENTS.

_____ _____

Signature of Applicant Date

It is our policy to provide employment, training, compensation, promotion, and other conditions of employment based on qualification, without regard of race, color, creed, religion, national origin, sex, age, veteran status or disability.

We are an Equal Opportunity Employer

CONFIDENTIAL REFERENCE LETTER

TO: Employer Name:_____

Attention of: _____

Address: _____ City, State, Zip: _____

Phone # _____ Fax: _____

RE: Applicant Name _____
Please Print

Dates Employed with above Employer: From:_____ To:_____

Title held while employed above:_____

□ Currently Employed □ Resigned □ Terminated □ Other:_____

One of your current/past □ Employees □ Students has applied for □ FT □ PT/PPV/PRN employment with our agency. This person has indicated current/past employment/association with your company and has requested this inquiry. The information you furnish will be held in strict confidence. Your prompt reply will be appreciated. In advance, thank you for your help in expediting this person's application.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of the information requested on the bottom of this form. I release the above agency and its employees from and all liability arising therefrom.

_____
Applicant's Signature Date

INFORMATION REQUESTED OF CURRENT/PAST EMPLOYER: (To be completed by current/past/employer)

Are the above dates correct? □ Yes □ No (Specify) _____

If former employee no longer works for you, would you rehire? □ N/A □ Yes □ No (Specify)_____

If former employee resigned, did employee give proper notice? □ N/A □ Yes □ No (Specify)_____

Please check:	***Below Average***	***Average***	***Above Average***	***No information***
Quality of work				
Job Knowledge				
Initiative				
Cooperation				
Attention				
Judgment				
Appearance				
Ability to work with others				
Dependable				
Self-Esteem				

Comments:_____

_____

_____
Signature of Person Completing This Section Title Date

It is our policy to provide employment, training, compensation, promotion, and other conditions of employment based on qualification, without regard of race, color, creed, religion, national origin, sex, age, veteran status or disability.

We are an Equal Opportunity Employer

CONFIDENTIAL REFERENCE LETTER

TO: Employer Name: _____

Attention of: _____

Address: _____ City, State, Zip: _____

Phone # _____ Fax: _____

RE: Applicant Name _____
Please Print

Dates Employed with above Employer: From: _____ To: _____

Title held while employed above: _____

☐ Currently Employed ☐ Resigned ☐ Terminated ☐ Other: _____

One of your current/past ☐ Employees ☐ Students has applied for ☐ FT ☐ PT/PPV/PRN employment with our agency. This person has indicated current/past employment/association with your company and has requested this inquiry. The information you furnish will be held in strict confidence. Your prompt reply will be appreciated. In advance, thank you for your help in expediting this person's application.

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Are the above dates correct? ☐ Yes ☐ No (Specify) _____

If former employee no longer works for you, would you rehire? ☐ N/A ☐ Yes ☐ No (Specify) _____

If former employee resigned, did employee give proper notice? ☐ N/A ☐ Yes ☐ No (Specify) _____

Please check:	***Below Average***	***Average***	***Above Average***	***No information***
Quality of work				
Job Knowledge				
Initiative				
Cooperation				
Attention				
Judgment				
Appearance				
Ability to work with others				
Dependable				
Self-Esteem				

Comments: _____

_____
Signature of Person Completing This Section Title Date