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 www.abcshomecare.com

EMPLOYMENT APPLICATION FOR HOME CARE ASSISTANT

Personal Information

Name	First _____ Middle Initial _____ Last: _____
Address	Street: _____ Apartment: _____ City: _____ State: _____ Zip: _____
Phone	Home: _____ Cell: _____ Other: _____
Electronic	Email Address: _____
Date of Birth	Month: _____ Day: _____ Year: _____
SIN	Social Insurance Number: _____
Gender	Male: _____ Female: _____
Language	What languages do you speak? _____ _____
Emergency Contact	Name & Phone Number of Person to contact in the event of an emergency: Local: _____ Out-of-Area: _____

Education

Formal	Diploma: _____ Certificate: _____ Degree: _____ Other: _____ Other: _____
Informal	Do you have current First Aid Certification (State Level): _____ Expiry Date: _____ Do you have current CPR? _____ Expiry Date: _____ Have you taken a Food Safety course? _____ Other: _____ (Specify) Other: _____ (Specify)

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Restrictions

Work Limitations	List any work limitations that you may have and briefly describe: Hearing: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Speech: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Lifting: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Health: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Physical: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Emotional: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Other: <input type="checkbox"/> Yes <input type="checkbox"/> No _____
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Availability for Work

Hours & Days Available for Work	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Short-notice <input type="checkbox"/> Split Shift Indicate Days and List Hours Available for Work: ___ Sunday: From: _____ To: _____ ___ Monday: From: _____ To: _____ ___ Tuesday: From: _____ To: _____ ___ Wednesday: From: _____ To: _____ ___ Thursday: From: _____ To: _____ ___ Friday: From: _____ To: _____ ___ Saturday: From: _____ To: _____ What is the minimum number of hours you will work in one day? _____ What is the maximum number of hours you will work in one day? _____
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Client Types and Work Duties

Type of Position(s) Preferred	<input type="checkbox"/> Home Maker <input type="checkbox"/> Personal Care <input type="checkbox"/> Companion <input type="checkbox"/> Live-In <input type="checkbox"/> Other: _____ <p style="text-align: center;"><i>(Specify)</i></p> Live-in care usually requires that you to in a client's home continuously for 3-4 days at a time every week. Indicate which shifts you will accept: <input type="checkbox"/> Weekdays (Monday a.m. to Friday a.m.) <input type="checkbox"/> Weekends: (Friday a.m. to Monday a.m.)
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Clients Not Willing/Able to Work With	<table style="width: 100%;"> <tr> <td><input type="checkbox"/> Dementias/Alzheimers</td> <td><input type="checkbox"/> Physical Disabilities</td> </tr> <tr> <td><input type="checkbox"/> Smokers</td> <td><input type="checkbox"/> Pets</td> </tr> <tr> <td><input type="checkbox"/> Mental Retardation</td> <td><input type="checkbox"/> Females</td> </tr> <tr> <td><input type="checkbox"/> Behavioral Disorders</td> <td><input type="checkbox"/> Males</td> </tr> <tr> <td><input type="checkbox"/> Elderly (over 65)</td> <td><input type="checkbox"/> Client use of marijuana for medicinal purposes</td> </tr> <tr> <td><input type="checkbox"/> Children</td> <td><input type="checkbox"/> HIVPositive/Aids</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table> <p style="text-align: center;"><i>(Specify)</i></p>	<input type="checkbox"/> Dementias/Alzheimers	<input type="checkbox"/> Physical Disabilities	<input type="checkbox"/> Smokers	<input type="checkbox"/> Pets	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Females	<input type="checkbox"/> Behavioral Disorders	<input type="checkbox"/> Males	<input type="checkbox"/> Elderly (over 65)	<input type="checkbox"/> Client use of marijuana for medicinal purposes	<input type="checkbox"/> Children	<input type="checkbox"/> HIVPositive/Aids	<input type="checkbox"/> Other: _____	
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Duties Not Willing/Able to Perform	<table style="width: 100%;"> <tr> <td><input type="checkbox"/> Bathing</td> <td><input type="checkbox"/> Housekeeping</td> </tr> <tr> <td><input type="checkbox"/> Grooming</td> <td><input type="checkbox"/> Laundry</td> </tr> <tr> <td><input type="checkbox"/> Oral Care</td> <td><input type="checkbox"/> Meal Preparation</td> </tr> <tr> <td><input type="checkbox"/> Dressing</td> <td><input type="checkbox"/> Shopping</td> </tr> <tr> <td><input type="checkbox"/> Bowel Care</td> <td><input type="checkbox"/> Transportation</td> </tr> <tr> <td><input type="checkbox"/> Bladder Care</td> <td><input type="checkbox"/> Medication Reminding</td> </tr> <tr> <td><input type="checkbox"/> Feeding</td> <td><input type="checkbox"/> Friendly Reassurance Phone Call/Home Visit</td> </tr> <tr> <td><input type="checkbox"/> Ambulation</td> <td><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> Bathing	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Grooming	<input type="checkbox"/> Laundry	<input type="checkbox"/> Oral Care	<input type="checkbox"/> Meal Preparation	<input type="checkbox"/> Dressing	<input type="checkbox"/> Shopping	<input type="checkbox"/> Bowel Care	<input type="checkbox"/> Transportation	<input type="checkbox"/> Bladder Care	<input type="checkbox"/> Medication Reminding	<input type="checkbox"/> Feeding	<input type="checkbox"/> Friendly Reassurance Phone Call/Home Visit	<input type="checkbox"/> Ambulation	<input type="checkbox"/> Other _____
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Experience	Indicate which of the following you have experience in: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <input type="checkbox"/> Bathing/Showering <input type="checkbox"/> Grooming <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Dressing <input type="checkbox"/> Bowel Care <input type="checkbox"/> Bladder Care <input type="checkbox"/> Feeding <input type="checkbox"/> Ambulation <input type="checkbox"/> Toileting </td> <td style="width: 50%; border: none;"> <input type="checkbox"/> Housekeeping <input type="checkbox"/> Laundry <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Shopping <input type="checkbox"/> Transportation <input type="checkbox"/> Medication Reminding <input type="checkbox"/> Friendly Reassurance Phone Call or Home Visit <input type="checkbox"/> Socialization <input type="checkbox"/> Other _____ <div style="text-align: right;"><i>(Specify)</i></div> </td> </tr> </table>	<input type="checkbox"/> Bathing/Showering <input type="checkbox"/> Grooming <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Dressing <input type="checkbox"/> Bowel Care <input type="checkbox"/> Bladder Care <input type="checkbox"/> Feeding <input type="checkbox"/> Ambulation <input type="checkbox"/> Toileting	<input type="checkbox"/> Housekeeping <input type="checkbox"/> Laundry <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Shopping <input type="checkbox"/> Transportation <input type="checkbox"/> Medication Reminding <input type="checkbox"/> Friendly Reassurance Phone Call or Home Visit <input type="checkbox"/> Socialization <input type="checkbox"/> Other _____ <div style="text-align: right;"><i>(Specify)</i></div>
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Assignment Location	Are you restricted in the geographical location you are willing/able to work? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ _____
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Transportation

Type	<input type="checkbox"/> Private Vehicle <input type="checkbox"/> Bus <input type="checkbox"/> Bike <input type="checkbox"/> Other: _____ <div style="text-align: right;"><i>(Specify)</i></div>
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Driver's License	Do you have a valid Driver's License?: _____
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Transporting Clients	Are you willing to transport clients in your private vehicle? _____ Do you have adequate vehicle insurance? _____ Are you willing to drive a client's vehicle? _____ Are you willing to escort a client in their own vehicle? _____ Are you willing to escort a client on public transportation? _____ Comments: _____ _____
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Abuse Investigation

	Have you ever been investigated for abuse, neglect or domestic violence? If "yes", explain: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____
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Reference Information

Work Related #1 (Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____: Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
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Work Related #2 (2nd Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____: Position Held: _____
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	Length of Employment: _____ Reason for Leaving: _____
Work Related #3 (3rd Last Position)	Company Name _____ Address: _____ Telephone No. & Email Address: _____: Supervisor's Name _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Personal #1	Name _____ Address: _____ Telephone No. & Email Address: _____: Nature of Friendship (<i>friend, co-worker, family etc.</i>) _____ (<i>Other than relative.</i>)
Personal #2	Name _____ Address: _____ Telephone No. & Email Address: _____: Nature of Friendship (<i>friend, co-worker, teacher etc.</i>) _____ (<i>Other than relative.</i>)

I certify that, to the best of my knowledge, the answers given are true and complete and that purposeful misrepresentation may result in rejection of my application. I authorize investigation of all statements contained in this application, as required. Additionally, I authorize former employers, references and any other individual/organizations to provide information to **ABCS HOME CARE INC** and I hereby release and discharge any of the above and **ABCS HOME CARE INC** from any liability of any kind or nature. I also understand that it is my responsibility to keep such information current and accurate by updating it as often as necessary

I agree to a physical examination, if requested, and understand that failure to meet any medical and/or health requirements for the position may prevent my employment with the Agency. I also understand that employment, for certain positions, may be conditional upon successful completion of a substance abuse screening test ,if part of the Agency's pre-employment policy.

I understand that, if hired, I may be required to provide proof that I am a citizen of the United States or proof that I am currently authorized to work in the United States.

Applicant's Signature

Date