Application for Employment

Care Planners Home Health LLC

346 Larpenteur Ave S
St. Paul, MN 55113
651-645-1070

Tell Us About Yourself

Last Name	First Name	MI	
Present Mailing Address	City	State	Zip
Home Phone (Inc. area code)	Cell Phone (Inc. area code)	County of residence	
Email (required)			
Emergency Contact (name & relationship to you)	Emergency Contact Phone		

Employmnet Conditions: Circle as many as you are willing to work.

Intermittent (on call as needed)	Temporary, full time	Seasonal, full time
Permanent, full time	Temporary, part-time	Seasonal, part-time
Permanent, part-time	On Call	Substitute

Position applied for: _____ Date available for work _____/_____/ _____

Are you at least 16 years of age? YES _____ NO _____

If yes, have you participated in a related school-based job-training program in caring for disabled people?

YES _____ NO _____

Please explain _____

Have you ever been convicted of a misdemeanor or felony for which jail sentence could have been or was imposed? MN Statues require Home Health Aides and Qualified Professionals to pass a criminal background study.

YES* No **If yes, attach a separate sheet describing your circumstances.**

Where did you hear about this job?

1. Job Service (Workforce Centers)
2. Newspaper
3. College/University school posting
4. Trade/Technical school posting
5. Internet (PEP Website/Craigslist)
6. Disabled persons media service
7. County Employee
8. County agency
9. Other _____

Are you a U.S. Citizen? Yes _____ No _____

If no, do you have a legal right to work in the U.S.? Yes _____ No _____

If yes, please explain. _____

_____

Are you fluent in a language (including sign language) other than English? Yes _____ No _____

If yes, what languages? _____

_____

EDUCATION AND TRAINING

Do you have a high school diploma or GED equivalency? Yes _____ No _____

College, University or Professional School Name & Location	Dates of Attendance	Did you graduate?	Major Fields
Business, Technical or Vocational School Name & Location	Dates of Attendance	Did you graduate?	Major Fields

PROFESSIONAL LICENSES

PROFESSIONAL LICENSES: IF THIS POSITION REQUIRES A LICENSE, CERTIFICATION, REGISTRATION OR SIMILAR CREDENTIAL, ATTACH A PHOTOCOPY OF THE CREDENTIAL AND COMPLETE THE INFORMATION BELOW.		
Credentialing Organization	**Profession**	**Number**
Example: MN BD of Nursing	*RN*	*000000000*

Additional Home Health Care Applicant Questions

This job will most likely require you to drive. You will need to sign a paper consenting or not consenting to MVR background check.

Do you have a valid driver's license? YES_____ NO_____ State _____ License No._____ Class_____

How far are you willing to drive to work? _____ (Miles)

This position may require you to drive at work. Is this an issue? Yes _____ No _____

WORK EXPERIENCE

Provide a complete description of all qualifying experiences, listing your most recent experience first.

Organization_____ Location_____

Position_____Supervisor_____Phone:_____

Length of Employment: From_____ To_____ Total Yrs./Mos._____
Month Year Month Year

Major Activities:

1. _____ Start Salary_____ Last Salary_____

2. _____ Type of Client Served_____

3. _____ Machines/equipment you use_____

How many days of work (other than vacation/holidays) have you missed in the past 6 months?_____

Over the past 12 months?_____ Reason:_____

Organization_____ Location_____

Position_____Supervisor_____Phone:_____

Length of Employment: From_____ To_____ Total Yrs./Mos._____
Month Year Month Year

Major Activities:

1. _____ Start Salary_____ Last Salary_____

2. _____ Type of Client Served_____

3. _____ Machines/equipment you use_____

How many days of work (other than vacation/holidays) have you missed in the past 6 months?_____

Over the past 12 months?_____ Reason:_____

Organization_____ Location_____

Position_____Supervisor_____Phone:_____

Length of Employment: From_____ To_____ Total Yrs./Mos._____
Month Year Month Year

Major Activities:

1. _____ Start Salary_____ Last Salary_____

2. _____ Type of Client Served_____

3. _____ Machines/equipment you use_____

How many days of work (other than vacation/holidays) have you missed in the past 6 months?_____

Over the past 12 months?_____ Reason:_____

Attach additional sheets if necessary. Be sure to include all information requested above.

IMPORTANT: Be sure to sign this application and read the following statements carefully.

I certify that all the information I have provided on the application is true and complete to the best of my knowledge. I understand that giving false information or omitting requested information could result in rejection of my application or dismissal if I am hired.

Signature _____ Date _____

In connection with this application for employment, I authorize Care Planners Home Health LLC to conduct an inquiry onto any job-related information contained in this application, including, but not limited to, present and former employers, and my records maintained by an educational institution relating to academic performance. Moreover, I hereby release Care Planners Home Health LLC from any and all liability of whatsoever nature by reason of requesting information from any person.

Yes Yes, but not present employer until job is offered. No

REFERENCES:

	NAME	ADDRESS	PHONE	RELATIONSHIP
1				
2				
3				

_____ ____/____/____

Applicant Signature **Date**

Care Planners Home Health LLC is an Equal Opportunity Employer

Return Complete Application to

Care Planners Home Health LLC

346 Larpenteur Ave W

St. Paul, MN 55113

Also needed are two forms of ID:

<u>These are preferred</u>

****Driver's License/State I.D. Card****

And

****Social Security Card****

OVERTIME WAGE APPROVAL

Please keep in mind that overtime begins after 40 hours per week are worked. It is your responsibility to obtain approval before working any overtime hours. If you do not receive prior approval from Christopher Hanson, your rights to an overtime wage rate will be waived. Without prior approval, all overtime hours will be paid at your regular rate.

Care Planners Home Health LLC telephone numbers:

651-645-1070 (office)

651-756-9003 (after hours)

Please sign and send to the office.

_____ ____/_____/_____

Care Planners Home Health LLC **Date**

EMPLOYEE MANUAL ACKNOWLEDEDGMENT FORM

By signing below I acknowledge that I have read a copy of Care Planners Home Health LLC employee manual. I realize it is my responsibility to read and understand the matters set forth in this manual. The manual is a guide to Care Planners Home Health LLC policies and procedures.

The employee handbook is designed to describe important information regarding Care Planners Home Health LLC. Any questions regarding the contents of the handbook should be directed to Chief Executive Officer of Care Planners Home Health LLC.

I have entered into my employment at Care Planners Home Health LLC voluntarily and acknowledge that there is no specific length of employment. I also acknowledge that I or Care Planners Inc may terminate my employment at will, with or without cause at any time, providing there is no violation of applicable Federal or State law.

Due to the nature of business, policies and benefits described here may change from time to time. I realize that revisions to this handbook may occur. Any notice of changes will be communicated through official notices. I acknowledge that this handbook is neither a contract of employment nor a legal document.

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EMPLOYEE NAME (PLEASE PRINT)

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EMPLOYEE SIGNATURE **DATE**

YOUR RESPONSIBILITY AS A TEMPORARY EMPLOYEE

According to Minnesota State Statute, Section 268.095, subdivision 2, paragraph D an applicant who, within five calendar days after completion of a suitable temporary job assignment from a staffing employer: {1.} fails without good cause to affirmatively request an additional job assignment, or {2.} refuses without good cause an additional suitable job assignment offered, shall be considered to have quit employment. It is your responsibility to contact Care Planners Home Health LLC for additional assignments. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact Care Planners Home Health LLC once an assignment ends. I also acknowledge that I have received a copy of this form.

_____ _____/_____/_____

Employee signature Date

_____

Employee {Please print your name}

_____ _____/_____/_____

Care Planners Home Health LLC Date

If you are terminated from your position or if you leave voluntarily, any property belonging to Care Planners Home Health LLC or any property belonging to Clients of Care Planners Home Health LLC must be returned to the office.

Your final check will be issued only after the property has been returned.

Signature:_____ Date:_____/____/_____

HIPAA PRIVACY RULE

HIPAA stands for the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

The law went into effect on August 21, 1996. It is Public law 104-191

These privacy rule standards address the use and disclosure of individual's health information, called protected health information.

This rule or law assures that Client's health information is properly protected while allowing the flow of health information needed to provide health care.

Every Client receiving care from Care Planners Inc. is protected under

the HIPPA law.

Any staff person who gives any medical information regarding any Client who receives services from Care Planners Inc. will be discharged immediately. HIPPA is a federal law making the offense a federal one, which is subject to federal charges as well.

I, _____have gone over the HIPPA rule on [date]
(employee signature)

_____. I understand the importance of not giving out medical information

(date)

regarding any Client I currently assist, will assist in the future, or have assisted in the past.

HIPPA LAW DEFINITION

HIPPA stands for Health Insurance Portability and Accountability Act.

HIPPA is a law that went into effect August 21, 1996.

The law was developed to ensure people have privacy regarding their medical information.

No one working with an individual is allowed to share any medical information of that individual. This includes family members. If a signed release is obtained, you may be able to share information with only the people who the Client has requested have the information.

The specific information that is protected is information, including such data that relates to:

***The individual's past, present, or future physical or mental health or condition.**

***The provision of health care to the individual, or**

***The past, present, or future payment for the provision of health care to the individual.**

Individually identifiable health information includes many common identifiers such as name, address, birth date, Social Security number.

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OVERTIME WAGE AGREEMENT

It is agreed that Home Health Aide/Homemaker, _____,

will not work more than 40 hours. The wages will be $_____ per hour for all hours worked. Must get prior approval for more than 40 hours per week from Christopher Hanson.

_____ _____

Home Health Aide/Homemaker (sign) **Date**

_____ _____

Care Planners Home Health Care Administrator **Date**