# Face-To-Face Interview

Applicant Name_____ Date _____

Interviewer Name_____

1. Tell me about your current/past work experience.

_____

_____

_____

_____

2. What do you like/dislike about current/past positions?

_____

_____

3. Hours/Days you are available to work. Holidays/Weekends?

_____

_____

4. Special Skills/Certifications_____
5. Why are you leaving your current position?_____
6. How did you hear of Supportive Hands Home Care?_____
7. What hourly rate are you looking for?_____

Interviewer Notes:

_____

_____

_____

_____

# Caregiver Job Description

As a caregiver, you provide a variety of non-medical services that allow seniors to remain in their homes. Companion services are those that stimulate, encourage, & assist an individual. Home services generally involves light housekeeping, errands or incidental transportation. Personal care services are personal in nature & often include assistance with activities of daily living.

- Providing companionship & conversation
- Providing stabilization & assistance with walking
- Preparing meals & cleaning up meal-related items
- Providing medication reminders & appointment reminders
- Performing light housekeeping tasks (dusting, vacuuming, making beds, changing linens, cleaning bathrooms, kitchens, etc)
- Washing & ironing laundry
- Running errands
- Accompanying clients to appointments
- Assisting with bathing
- Assisting with grooming
- Assisting with toileting & incontinence issues

Secondary responsibilities include the following:

- Contributing to a positive environment to enhance a client's quality of life
- Performing other reasonable duties as assigned
- Reporting hours according to office policy
- Reporting any significant changes in a client's needs or living conditions
- Regularly communicating with supervisor & office staff

**Essential Qualifications**

An individual must possess the minimum education, experience and skills to perform the primary & secondary responsibilities the job includes. Additional qualifications include:

- Ability to lift, pull or push 25 pounds
- Ability to bend, twist, stoop, kneel, & reach
- Ability to withstand exposure to dust, mold, mildew & cleaning solutions
- Ability to treat & care for clients & their property with dignity & respect
- Ability to adapt to various living environments & locations
- Ability to communicate with clients in a friendly & congenial manner

**Potential Qualifications**

The caregiver position may require you to run errands & provide incidental transportation for a client using your vehicle or a client's vehicle.

**Potential Schedules**

The caregiver position provides opportunities for a variety of shifts around the clock, including overnights.

Signature _____ Date _____

# Skills/Experience Assessment

Please check ALL that apply.

| Skilled: | Willing to Learn: |
|---|---|
| | Assist with bathing |
| | Catheter Experience |
| | Colostomy Experience |
| | Hospice Experience |
| | Incontinent Experience |
| | OK with Client Srnoking |
| | Oxygen Tank Experience |
| | Gait Belt Experience |
| | Hoyer Lift |
| | Transfers |
| | Steady Ambulation |
| | . oxygen Tank |
| | Sit to Stand Lift |
| | Pivot Board |
| | Skill with Difficult Clients |

Client Diagnosis

| Skilled: | Willing to Learn: |
|---|---|
| | Dementia |
| | Diabetes |
| | Multiple Sclerosis |
| | Alzheimer's |
| | Brain injury |
| | Blindness |

Signature _____ Date _____

# Availability Form

*EMPLOYEE:* Show the times and days you are available for work. Whenever your schedule changes, request this form, complete it and return it to your manager or supervisor. Any changes must be presented to a manager or supervisor 10 days in advance.

Employee Name:_____ Position: _____

I am available to work the following days and times:

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| From | | | | | | | |
| To | | | | | | | |

If there are changes to original availability, make changes below (manager must approve changes)

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| From | | | | | | | |
| To | | | | | | | |

HR Initials_____

Notes/Explanations *(ex; School Mon-Fri 7:00am-3:00pm)*

Employee Signature:_____ Date:_____

HR Coordinator Signature:_____ Date:_____

# Emergency Contact Information

Primary Contact Name

Relationship

Primary Telephone#

Secondary Telephone#

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Secondary Contact Name.

Relationship

Primary Telephone #

Secondary Telephone#

---

Additional Contact Name

Relationship

Primary Telephone #

Secondary Telephone #

---

Signature

Date

AUTHORIZATION FOR BACKGROUND CHECKS

I authorize Supportive Hands Home Care to obtain my background report, including investigative consumer reports. I also agree that a copy of this form is valid like the signed original. I understand that, as allowed by law, Supportive Hands Home Care may rely on this authorization to order additional background reports, including investigative consumer reports, (1) during my employment and (2) from companies other than ADP Screening and Selection Services without asking me for my authorization again, as allowed by law. I understand the Company may order a background report under my legal name and any other names I may have used.

I also authorize the following agencies and entities to disclose to ADP Screening and Selection Services arid its agents all information about or concerning me, as allowed by law, including but not limited to: my past or present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities; motor vehicle records agencies; if applicable, worker's compensation injuries; all other private and public sector repositories of information; and any other person, organization, or agency with any information about or concerning me. The information that can be disclosed to ADP Screening and Selection Services and its agents includes, but is not limited to, information concerning my employment history, earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses and substance abuse testing.

**Please print your legal name:**

Last Name_____ First_____ Middle_____

Signature

____/____/_____
(Month/Day/Year)

THE REMAINDER OF THIS DOCUMENT IS INTENTIONALLY LEFT BLANK

BACKGROUND CHECK INFORMATION

The information requested below is collected solely for the purpose of aiding Supportive Hands Home Care in running a background check in connection with your application for employment. The employer is requesting that you provide this information to assist in conducting a thorough background check.

First Name _____ Middle Name _____ Last Name _____

For Identification Purposes Only: Date of Birth / / (Month/Day/Year)

Social Security Number _____

Driver's License Number _____ State Issuing License _____

Enter Nickname(s) Used_____
Enter Any Other Names Used (Including maiden names):
First Name _____ Middle Name _____ Last Name _____
First Name _____ Middle Name _____ Last Name _____

Addresses Within The Past Two Years not in PA (use a separate sheet as needed}

Present Street Address _____

City/State/ZIP _____

Prior Street Address _____

Prior City/State/ZIP _____

From / / (Month/Day/Year) To / / (Month/Day/Year)

# Investigative Consumer Report Disclosure

## Notice and Authorization

This notice is to inform you that Supportive Hands Home Care may obtain an Investigative Consumer Report, which might include information with respect to your character, general reputation, personal characteristics and/or mode of living). In connection with your employment application, an Investigative Consumer Report involves personal interviews with sources, such as neighbors, friends or associates, as well as, a criminal background check and motor vehicle report. Such a report will be used for employment purposes only.

Under federal law, you have the right, within a reasonable period of time after receipt of this notice, to make a written report for the nature and scope of the investigation requested by Supportive Hands Home Care and for a summary of your rights under the Fair Credit Reporting Act.

The fact that Supportive Hands Home Care may obtain an Investigative Consumer Report does not mean, and should not be construed to mean, that Supportive Hands Home Care has otherwise decided to offer you employment.

By signing this form below, you authorize Supportive Hands Home Care to obtain, or cause to be obtained, an Investigative Consumer Report. You affirm that you are not disqualified from employment due to a conviction of one of the enumerated criminal conviction provisions. In addition, you do not have a history of a conviction for violent crime and you were never dismissed from employment due to abuse or neglect of clients or residents.

If hired, this authorization shall remain in effect and serve as continuing authorization for Supportive Hands Home Care to obtain consumer reports at any time during your employment with Supportive Hands Home Care.

_____ _____

Signature Date

# Provisional Hire Acknowledgement Form

**2-Step PPD**

I have read or have had explained to me that Supportive Hands Home Care utilizes a 2-step PPD TB, Screening Procedure, I understand the agency requires that applicants and persons, who are employed or rostered, be tested for Mycobacterium Tuberculosis and be free from active M. Tuberculosis prior to consumer contact, and that documentation be completed initially and annually, Supportive Hands Home Care will follow the Centers for Disease Control Guidelines for preventing the transmission of M. Tuberculosis in Health Care settings, I understand that the 2-step PPD requires a minimum of 14 days to complete and will require me to have 2 tests and visual checks of the injection area,

_____ _____

Signature Date

Provisional Employment

I have read or have had explained to me the Supportive Hands Home Care Provisional Hiring Policy and understand that I may be hired for employment on a provisional basis, pending receipt of a criminal history report.

I understand that if I have been a resident of the Commonwealth of Pennsylvania for a period of 2 years or more from the date below, the period for *my* provisional hire may not exceed 30 days of date of hire.

I understand that if I have been a resident of the Commonwealth of Pennsylvania for less than 2 years from the date below, the period for my provisional hire may not exceed 90 days of date of hire.

_____ _____

Signature Date

# Employee Non-Compete Agreement

For good consideration and as an inducement for Supportive Hands Home Care employ the undersigned, Employee hereby agrees not to directly or indirectly compete with Supportive Hands Home Care and its successors and assignees during the period of employment and for a period of one year following termination of employment and notwithstanding the cause or reason for termination.

The term "not compete" as used herein shall mean that the employee shall not own, manage, operate, consult or be employed in a business substantially similar to or competitive with the present business of Supportive Hands Home Care or such other business activity in which Supportive Hands Home Care may substantially engage during the term of employment.

Initials _____

Supportive Hands Home Care and the services it renders are made possible only with a substantial investment in business-related costs including, but not limited to, advertising, recruiting, testing, and training of substantial staff. The caregiver understands and agrees that, as a condition of being referred to its clients by Supportive Hands Home Care before or after termination of services, the caregiver, any family member or friend of the caregiver, shall not be employed or otherwise employed by the client, or any other competing company for; period of twelve (12) months, following termination services. For any breach in this part of the agreement, the caregiver will pay to Supportive Hands Home Care the sum of seven thousand ($7,000) dollars, as liquidated damages. Caregiver agrees that this sum is a fair and reasonable estimate of the damages incurred by Supportive Hands Home Care and does not constitute a penalty.

Initials _____

The employee acknowledges that the company shall or may in reliance of this agreement provide employee access to trade secrets, customers and other confidential data. Employee agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose same to any third party.

Initials _____

This agreement shall be binding upon and insure to the benefit of the parties, their successors, assignees, and personal representatives.

_____ _____

Signature Date

_____

Witness Signature

# Nondiscriminatory Statement to Department of Health: Section 51.12 Supportive Hands Home Care

"This agency has agreed to comply with the provisions of the Federal Civil Rights Act of 1964 and the Pennsylvania Human Relations Act and all requirements imposed pursuant thereto the end that no person shall, on the grounds of race, color, national origin, ancestry, age, sex, religious creed or disability, be excluded from participation in, be denied benefits of or otherwise be subject to discrimination in the provision of any care or service.

Print Name: _____ Signature: _____

# Civil Rights Compliance Employee Awareness

In accordance with applicable Federal and State Civil Rights laws and regulatory requirements, you as an employee engaged in the provision of services, may not directly or indirectly:

refuse, withhold, or deny services of this agency to any present or prospective client because of their race, color, religious creed, handicap, ancestry, national origin, limited English proficiency (LEP), age or sex.

Furthermore, as an employee of this facility, you have the right to:

file a complaint of discrimination if you feel you have been discriminated against on the basis of your race, color, religious creed, handicap, ancestry, national origin, limited English proficiency (LEP), age or sex.

Complaints of discrimination may be filed with any of the following:

American with Disabilities Act Director
Governor's Office
Room 238 Main Capitol
Harrisburg, PA 17105

Department of Public Welfare
Bureau of Equal Opportunity
Southeast Regional Office
11058 Philadelphia State Office Building
1400 Spring Garden Street
Philadelphia, PA 19130

U.S. Department of Health & Human Services
Offices for Civil Rights
Suite 372, Public Ledger Building
150 S. lndependence Mall West
Philadelphia, PA 19106-9111

PA Human Relations Committee
711 Philadelphia State Office Building
1400 Spring Garden Street
Philadelphia, PA 19130

_____ _____
Signature Date

# PrivacyPolicy/HIPAA Consumer Confidentiality

All Supportive Hands Home Care records and Information relating to Supportive Hands Home Care's clients are confidential and employees must, therefore, treat all matters accordingly, all employees of Supportive Hands Home Care are required to follow the Health Insurance Profitability and Accountability Act (HIPAA) of 1996 regulations. This includes keeping the client's medical information private.

Employees sign this agreement stating that they will not speak about clients in any public venue not related to work as this is a serious HIPAA violation and is strictly prohibited.

No Supportive Hands Home Care related information, including without limitation: documents, notes, files, records, oral information, and computer files or similar materials (except in the ordinary course of performing duties on behalf of Supportive Hands Home Care), may be removed from Supportive Hands Home Care's premises without written permission from Supportive Hands Home Care's client, family, or Power of Attorney (POA). Additionally, the contents of Supportive Hands Home Care's records or information otherwise obtained regarding business may not be disclosed to anyone, except where required for a business purpose.

Employees must not disclose any confidential information, purposefully or inadvertently through casual conversation, to any unauthorized person inside or outside of the company.

Employees who are unsure about the confidential nature of specific information are directed to ask their supervisor for clarification. Employees will be subject to appropriate disciplinary action, up to and including dismissal, for knowingly or unknowingly revealing information of a confidential nature.

Signature Date

# Authorization to Release Information

I certify that the information given by me in my application is true and correct to the best of my knowledge. I authorize any persons, schools, employees or other organizations named in the application to provide Supportive Hands Home Care with any relevant information that may be required to arrive at an employment decision. I release all such persons from any liability or damages due to providing such information, I understand that any misrepresentations, falsification, or material omission of information on this application may result in my failure to receive an offer of employment or if I am hired, my termination from employment. I understand and agree that:

A. Although every effort will be made to accommodate individual preferences, business needs at times make the following conditions mandatory: overtime, shift work, rotating work schedule, or a work schedule other than Monday through Friday. I understand and accept these conditions of employment.
B. According to state law, Supportive Hands Home Care may require a health screening for communicable disease, pre-employment physical and/or substance abuse testing as a precondition to employment,

I understand that nothing in my employment application or in the granting of an interview is intended to create an employment contract between Supportive Hands Home Care and myself for either employment or
for the providing of any benefit. I also understand that any job I may be offered will not be for any set period of time. My employment may be terminated at any time of my own free will or that *of* my employer.

_____ _____

Signature Date

# Worker's Compensation Information

The Workers' Compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury .

Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying Workers' Compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

You should immediately report any injury or work-related illness to your employer.

Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation
1171South Cameron Street, Room 103
Harrisburg, PA 17104-2501

www.state.pa.us
PA Keyword: workers comp

Telephone Number within PA: (800) 482 2883
Telephone Number outside of PA: (717} 772-4447
TTY {hearing and speech impaired only): (800) 362-4228

Signature _____ Date _____

Witness Signature _____ Date _____