LOVEMOST CARE

Please Print OR BOTH WAY

Application for Employment

Equal access to programs, services, and employment is available to all persons. Those applicants requiring reasonable accommodations to the application and/or interview process should notify a representative of Home & Hospital Medical Personnel, Inc.

Date of Application _____ Position(s) applying for _____

Name _____
Last First Middle

Address _____
Street City State Zip Code

Primary Phone # _____ *Can you receive texts? _____ Secondary Phone # _____

Date of Birth _____ Social Security # _____

How did you hear about Home & Hospital? _____

Have you ever been employed here before? _____

Are you legally eligible for work in this country ……...Yes☐ No ☐

What date are you available to start work? _____

Type of employment desired…… Full Time ☐ Part Time ☐

Hours/Shifts/Days preferred_____

Are you able to meet the attendance requirements of this job? ……..Yes☐ No ☐

Have you been convicted of a crime in the past seven years? ……..Yes☐ No ☐

If yes, please explain_____

Conviction will not necessarily be a bar to employment. Each instance and explanation will be considered in relation to the position for which you are applying.

Employment History

Provide the following information for your past three employers, assignments, or volunteer activities, starting with the most recent.

From:	To:	Employer	Telephone
Job Title		Address	
Immediate Supervisor & Title		Summarize the nature of work and job responsibilities	
Reason for leaving		Hourly Rate/Salary: Start $ _____ Per _____ Final $ _____ Per _____	

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Job Title:		Address	
Immediate Supervisor & Title		Summarize the nature of work and job responsibilities	
Reason for leaving		Hourly Rate/Salary: Start $ _____ Per _____ Final $ _____ Per _____	

Skills and Qualifications

Summarize any training, skills, licenses, and/or certificates that may qualify you as being able to perform job-related functions in the position for which you are applying.

Educational Background

Name & Location	Year Completed	Did you graduate?	Course of Study
High School			
College		**Major** **Degree**	
Other			

References

Name	Telephone #	Years known

Emergency Contact(s)

Name	Relationship	Telephone #

I understand that if I am employed, any misrepresentation or material omission made by me on this application will be sufficient cause for cancellation of this application or immediate discharge from the Home & Hospital Medical Personnel, Inc.'s service, whenever it is discovered.

I give Home & Hospital Medical Personnel, Inc. the right to contact and obtain information from all references, employers, educational institutions and to otherwise verify the accuracy of the information contained in this application. I hereby release from liability Home & Hospital Medical Personnel, Inc. and its representatives for seeking, gathering and using such information and all other persons, corporations or organizations for furnishing such information.

Home & Hospital Medical Personnel, Inc. does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by local, state or federal law.

The application is current for only 60 days. At the conclusion of this time, if I have not heard from Home & Hospital Medical Personnel, Inc. and would still like to be considered for employment, it will be necessary to fill out a new application.

If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice. Home & Hospital reserves the same right to terminate my employment at any time, with or without cause and without prior notice, except as required by law. This application does not constitute an agreement or contract for employment for any specified period or duration. I understand that no representative of Home & Hospital Medical Personnel, Inc. other than an authorized officer has the authority to make any assurances to the contrary. I further understand that any such assurances must be in writing and signed by an authorized officer.

I understand that it is this company's policy not to refuse to hire a qualified individual with a disability because of that person's need for a reasonable accommodation as required by the ADA.

I also understand that if I am hired, I will be required to provide proof of identity and legal work authorization.

I represent and warrant that I have read and fully understand the foregoing and seek employment under these conditions.

***Signature of Applicant _____ Date _____**

TO BE COMPLETED BY APPLICANT:

APPLICANT NAME (PLEASE PRINT) SOCIAL SECURITY NUMBER

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

DATES OF EMPLOYMENT POSITION(S) HELD

REASON FOR LEAVING

I have applied for a position with Home & Hospital Medical Personnel, Inc. Please complete and return this evaluation for me. I hereby authorize you to disclose any and all information concerning my employment with your firm to Home & Hospital Medical Personnel, Inc. I Understand this is in accordance with all Federal and State laws.

/ /

SIGNATURE OF APPLICANT DATE (Mo/Day/Yr)

TO BE COMPLETED BY FORMER EMPLOYER:

The applicant named above has applied for a position with Home & Hospital Medical Personnel, Inc. and has listed you as a previous employer. We would appreciate your assistance in verifying this applicant's employment and in evaluating his/her job performance so we will be able to maintain our high standards. All information provided will be held in strictest confidence. Thank you.

1. Does the information above correspond with your records..... Yes No

2. Position Held _____

3. Would you rehire this applicant..... Yes ☐ No ☐

4. Is there any reason, Medical or Other, that would interfere with this applicant performing his/her job..... Yes ☐ No ☐

5. Reason for termination _____

EVALUATION	EXCELLENT	GOOD	AVERAGE	POOR
ATTENDANCE				
PUNCTUALITY				
DEPENDABILITY				
QUALITY OF WORK				
JOB KNOWLEDGE				
ACCEPTS SUPERVISION				
PERSONAL APPEARANCE				
CONDUCT				

/ /

Information Supplied by Title Date(Mo/Day/Yr)

TO BE COMPLETED BY APPLICANT:

APPLICANT NAME (PLEASE PRINT) SOCIAL SECURITY NUMBER

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

DATES OF EMPLOYMENT POSITION(S) HELD

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Information Supplied by Title Date(Mo/Day/Yr)

Home & Hospital Medical Personnel Inc.

Home Health Aide ---- *Skills Checklist*

Type of Procedure	Recent Training	Recent Experience	Feel Confident	Need Assistance
1. Complete bed bath				
2. Total A.M. care				
3. Total P.M. care				
4. Lifting and turning (body mechanics)				
5. Positioning of patients				
6. Meal planning & preparation				
7. Empty catheter bag				
8. Colostomy care				
9. Applying restraints to a patient (Dr. Order)				
10. Changing dressings (non-sterile)				
11. Assisting with ambulation				
12. Assisting with dressing patient				
13. Diabetic urine testing				
14. Taking vital signs (TPR)				
15. Bed making (occupied / unoccupied)				
16. Charting intake & output (I&O)				
17. Using a commode chair				
18. Assisting a patient in bathroom				
19. Feeding a patient				
20. Transferring patients (bed to chair) a. CVA patient b. Amputee patient c. Quadriplegic patient d. Paraplegic patient				
21. Using a Hoyer lift				
22. Prepare special diets (Kosher, Diabetic, etc.)				
23. Charting Home Health Aide notes (observing and reporting)				
24. Using bedpan & urinal				
25. Care of AIDS patients				

Comments:

_____

_____

_____

_____ _____

Interviewer Signature / Date Signature / Date

EMPLOYEE W-4 INFORMATION FORM

Employee Name _____

Address _____

_____

_____

Email Address _____

Home # _____

Cell # _____

Date of Birth _____

Social Security # _____

Marital Status _____

Dependents _____

Date of Hire _____

Rate of Pay _____

Additional Withholdings _____

ALL EMPLOYEES WILL BE USING DIRECT DEPOSIT……..FILL OUT BELOW

Bank Name _____

Bank Account Number _____

Bank Routing Number _____

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2014

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, and • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Department of Homeland Security
U.S. Citizenship and Immigration Services

OMB No. 1615-0047; Expires 03/31/07

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien #) A _____
- ☐ An alien authorized to work until _____

(Alien # or Admission #) _____

Employee's Signature	Date *(month/day/year)*

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title:				
Issuing authority:				
Document #:				
Expiration Date *(if any)*:				
Document #:				
Expiration Date *(if any)*:				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.
Document Title: _____ Document #: _____ Expiration Date (if any): _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

AUTHORIZATION FOR BACKGROUND CHECKS

After carefully reading this Background Check Disclosure and Authorization form, I authorize the Company to order my background report, including investigative consumer reports. I understand that the Company may rely on this authorization to order additional background reports, including investigative consumer reports, during my employment without asking me for my authorization again as allowed by law.

I also authorize the following agencies and entities to disclose to ADP Screening and Selection Services and its agents all information about or concerning me, 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. Workers' compensation information will only be requested in compliance with federal Americans with Disabilities Act and/or any other applicable federal, state or local laws and only after a conditional job offer is made. 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.

I agree the Company may rely on this authorization to order background reports, including investigative consumer reports, from companies other than ADP Screening and Selection Services without asking me for my authorization again as allowed by law. I also agree that a copy of this form is valid like the signed original. I certify that all of the personal information I provided is true and correct.

Last Name _____ First _____ Middle _____

Maiden/Other Names _____ Years Used _____

If you live or work for the Company in California, Minnesota or Oklahoma: Check this box if you would like a free copy of your background check report: ☐

_____ _____/_____/_____
Signature Date: (Month/Day/Year)

If required, notarize here. When using an embossed seal, please shade with a pencil before faxing.

Subscribed and sworn before me:

_____
Notary Public Signature

_____
Date

_____
My Commission Expires

LOVEMOST CARE

COMPETENCY EVALUATION EXAM

PLEASE CIRCLE THE CORRECT LETTER

1. When a patient becomes angry, the aide should:

   a. shout back at the patient
   b. quietly continue giving care and try to calm the patient
   c. slap the patient to calm him/her down
   d. stop talking to the patient

2. You have been told by your supervisor to give Mrs. Edwards a bath as part of the morning care. Mrs. Edwards is tired and does not want a bath. Your best response to her would be:

   a. “No excuses, Mrs. Edwards, it’s time for your bath.”
   b. “I see you would rather not bathe now, but it’s important. Let’s pick a time because I have to bathe you before I leave this morning.”
   c. “I have a lot to do; I have to bathe you now.”
   d. “Okay, but now you can’t have any dessert.”

3. Your patient refuses to eat, saying she is not hungry. You know it is very important that she eat her meals. Your best response would be:

   a. “If you don’t want to eat, you don’t have to.”
   b. “I spent a lot of time preparing your lunch, so you have to eat it now.”
   c. “Maybe you would like to wait a while. I can serve you lunch a little later.”
   d. “Food is very expensive and you are being wasteful.”

4. The first step when transferring a patient out of bed to a wheelchair is:

   a. pull back the covers on the bed
   b. dangle the patient’s legs over the bed
   c. tell the patient what you are going to do
   d. put on the patient’s slippers

5. You go to Mrs. Adams house on Monday morning and as you are giving her a bath, you notice many suspicious looking bruises. She says, “I don’t want to talk about it.” You should:

   a. respect Mrs. Adams wishes and do nothing
   b. call your supervisor and report the bruises
   c. call her son at work and ask him if he hit her
   d. ignore the problem

6. Your patient's temperature when taken orally is 100 degrees. You should:

   a. tell her this is normal and continue with your work
   b. tell her this is a high fever, but it will come down
   c. tell her that her temperature is slightly higher than normal and that you will call your supervisor
   d. call an ambulance immediately

7. Which of the following should a home health aide report to their supervisor?

   a. chest pain
   b. swelling of any part of the body
   c. any redness or breakdown of skin
   d. all of the above

8. A home health aide must write down his/her activities with a patient:

   a. once a week
   b. every two hours
   c. every day that service is provided
   d. only when there are important changes to report

9. It is important for a home health aide to document which of the following:

   a. a change in the patient's skin color
   b. a change in the patient's mood
   c. a change in the patient's appetite
   d. all of the above

10. The best way for an aide to prevent infection from spreading is:

    a. air the patient's room
    b. damp-dust the patient's room
    c. wash hands before and after each patient contact
    d. change linens daily

11. An aide's hands should be washed:

    a. after blowing his/her nose or sneezing
    b. after using the restroom
    c. before preparing food
    d. all of the above

12. Care of a patient with a catheter includes:

    a. washing the patient's skin area surrounding the catheter
    b. wiping the catheter tube with an antiseptic swab making one stroke per swab
    c. starting at the urinary opening and wiping toward the drainage bag
    d. all of the above

13. Latex gloves should be worn whenever:

    a. working with a patient where there is exposure to blood, feces, or urine
    b. assisting a patient with ambulation
    c. feeding a patient
    d. preparing a meal for a patient

14. Home Health Aides are not permitted to:

    a. bathe a patient with bedsores
    b. take a patient's temperature rectally
    c. cut toe nails
    d. transfer a patient from the bed to a wheelchair

15. Before doing a non-sterile dressing change, a home health aide must:

    a. wash his/her hands
    b. wear latex gloves
    c. gather supplies
    d. all of the above

16. A patient who is incontinent has:

    a. a gall bladder condition
    b. constipation
    c. diabetes
    d. no control of the bladder muscles

17. The normal oral temperature is:

    a. 96.8
    b. 98.6
    c. 99.8
    d. 100.00

18. The normal pulse rate for an adult is:

    a. 110 – 130
    b. 16 to 20
    c. 60 to 90
    d. 25 to 40

19. The normal adult respiration rate is:

    a. 14 to 20
    b. 5 to 10
    c. 10 to 15
    d. 25 to 30

20. Problems of long periods of bed rest include:

a. contractures
b. bedsores
c. constipation
d. all of the above

21. The most important reason to keep the patient's living area clean is that:

a. a clean house looks neater and smells better
b. a family is more comfortable in a clean, neat home
c. a clean, neat home provides good morale
d. it lessens the danger of infection to the patient

22. When making an occupied bed, the aide should:

a. move the patient to the opposite side of the bed
b only change the top sheet
c. always turn off the television
d. never change the bed if the patient feels weak

23. When doing laundry or cleaning, you should never:

a. wear plastic gloves
b. vacuum in a room where a bedridden patient is in bed
c. mix bleach with ammonia
d. all of the above

24. Mrs. Johnson has difficulty breathing. She has an oxygen tank in her room. Remember that:

a. you should not enter her room while it is operating
b. the oxygen is very inexpensive, so you can leave it on even when she does not need it
c. no smoking or sparks of any kind should be around the oxygen, or a fire can start
d. none of the above

25. When a diabetic patient is nervous, dizzy, perspiring and appears to be going into insulin shock, the aide should call the supervisor and give the patient:

a. a blanket to keep warm
b. a large glass of water
c. an extra insulin shot
d. a lump of sugar or a glass of orange juice

26. If a patient complains of pain in the chest and has difficulty breathing, the aide should:

a. call an ambulance
b. call the supervisor
c. have the patient lie down
d. all of the above

27. Symptoms of heart attack include:

a. chest, jaw, or left arm pain
b. shortness of breath
c. indigestion
d. all of the above

28. In case of poisoning, the following should be contacted first:

a. family member
b. neighbor
c. “911”
d. a taxi

29. Shock is usually caused by which one of the following:

a. a broken bone
b. thirst
c. severe bleeding
d. overeating

30. Which of the following should not occur while giving a patient a tub bath?

a. assist the patient to undress if he/she needs help
b. allow visitors to watch
c. assist the patient to the bathroom as needed
d. help the patient wash him/herself as needed

31. Which of the following is true?

a. all older people prefer to be left alone
b. all older people experience a loss of hearing
c. some older people experience a decreased sense of touch and can suffer burns because of it
d. all people grow less polite as they get older

32. Which of the following is true?

a. if a dying person has hope of a cure or a miracle, it is a good idea to tell them that they are not being realistic
b. older people lose their need for privacy
c. most older people feel more comfortable being treated like a child
d. none of the above

33. A patient accuses you of stealing money. You should:

a. argue with the patient
b. call the police
c. call your supervisor immediately
d. tell your client that he or she is confused and there was/is no money missing

34. Which of the following is true?

a. it is important to ignore a confused patient when he/she complains to you
b. a person over the age of 65 cannot learn anything new
c. all older people are irritable most of the time
d. none of the above

35. Which of the following is the wrong thing to do?

a. discuss your patients with your family and friends
b. talk to your patient while bathing them
c. allow your patients to talk about their past
d. laugh along with your patient

36. Which of the following would be the best breakfast for a patient on a low-salt diet?

a. egg, bacon, buttered toast, orange juice and milk
b. shredded wheat with milk and bananas
c. grilled cheese sandwich and tomato juice
d. pancakes with syrup, sausages, half grapefruit and milk

37. Foods that help prevent constipation are:

a. whole grain breads and cereals
b. raw vegetables
c. prune juice
d. all of the above

38. A diabetic diet should include:

a. pancakes with syrup
b. canned peaches in heavy syrup
c. mashed potatoes and gravy
d. water-packed canned fruit or fresh fruit

39. When feeding a patient that cannot feed him/herself, it is important to:

a. feed slowly in small amounts
b. make sure the food is not too hot or too cold
c. not rush the patient
d. all of the above

40. Milk is a good source of:

a. fiber
b. potassium
c. calcium
d. vitamin C

41. Oranges and bananas are an excellent source of:

a. iron
b. cholesterol
c. calcium
d. potassium

42. When checking the patient's temperature rectally, the aide should:

a. position the patient on one side and cover the patient with a sheet
b. lubricate the bulb tip with water-soluble jelly
c. insert the bulb end of the thermometer about one and one half inches into the patient's rectum
d. all of the above

43. The position of a bedridden patient should be changed:

a. once a day
b. never
c. every two hours
d. every twenty minutes

44. A urinary catheter is:

a. an infection of the urinary tract
b. a bag used to collect waste from the intestines
c. a bedpan designed to collect urine
d. a tube inserted into the bladder to drain urine

45. Passive range of motion exercises are done:

a. completely by the patient
b. completely by the aide for the patient
c. completely by machine
d. partially by machine and partially by the patient

46. The purpose of mouth care for a patient is to:

a. improve the patient/aide relationship
b. help the older person speak clearly
c. help the patient's teeth and gums remain healthy
d. none of the above

47. When giving a bed bath, the aide should:

a. first wash the patient's face
b. allow the patient to wash his/her private area if the patient can
c. change the bath water after washing the patient's feet
d. all of the above

48. If giving a bed bath, you would need:

a. soap
b. wash cloth
c. wash basin
d. all of the above

49. When walking with a patient who has weakness on one side, the aide should:

a. walk on the patient's weak side
b. walk on the patient's strong side
c. stay near furniture, in case the patient starts to fall
d. walk slightly ahead of the patient

50. Before transferring the patient to the wheelchair, the most important thing the aide should do is:

a. make sure the client is dressed
b. lock the wheels of the wheelchair
c. offer the patient the bedpan
d. bathe the client