AGENCY EMPLOYEE APPLICATION

Equal access to programs. Services employment is available to all persons. Those applicants requiring accommodation for the application and or interview process should contact a representative of the Personnel Department.

Name: ____
Last First Middle

Date of application: _____/_____/__________ Date available: _____/_____/_________

Address: ____

City: _______________________ State: _____________ Zip Code: ______________

E-Mail Address________________________________

Home Phone #: ______________________ Cell Phone #:_________________________

Date of Birth: _____/_____/___________ SSN: _______________________________

Position applied for: ____

Professional Status : (Circle one) RN LPN HHA CNA NMA OTHER

_____Full Time _______Part Time CPR certification through: ___________________

State License/Certification: __________________________ Expiration: ___/___/_____

Name of Spouse/Significant other:____

Phone # _____________________________

Additional Emergency Contact:____

Phone # _____________________________

I would like my check (circle one)

Mailed Direct Deposit

How did you hear about us?: ____

Have you ever applied for a position here before? ___________ When: ______________

If necessary, the best time to call you at home is: ______________________________

May we contact you at work?_____________ The best time to call: ________________

Are you on lay-off and subject to recall?: _______ Have you ever been bonded?_______

My signature below indicates that the information submitted is true and correct to my knowledge and that I am aware that any falsification of information on this application for employment may be grounds for immediate termination.

____

Applicant Signature   Date

All Saints Home Care

EMPLOYMENT HISTORY

List your previous employment history starting with the most recent including military experience.

From: To: Employer: Telephone:

Job Title: Address:

Immediate supervisor and title:

From: To: Employer: Telephone:

Job Title: Address:

Immediate supervisor and title:

From: To: Employer: Telephone:

Job Title: Address:

Immediate supervisor and title:

From: To: Employer: Telephone:

Job Title: Address:

Immediate supervisor and title:

EDUCATION

High School:	Graduate: Yes/No	
City and State:		
Vo Tech:	Graduate: Yes/No	Major:
City and State:		
College/University:	Graduate: Yes/No	Major
City and State:		
Other:	Graduate: Yes/No	Major
City and State:		

EMPLOYMENT AGREEMENT

I understand that my employment with All Saints Home Care, Inc. is contingent upon license/certification verification and also upon the results of my KBI and KDHE check.

I understand that if either one is not current or up to standards, I will be immediately terminated. This also includes annual certification checks and random screening at company will. Termination is also probable if licenses and certifications are not kept current.

I certify that all the information provided by me in this application is true and complete. I understand that any misstatement, falsification or omission of information is grounds for refusal to hire or, if I am hired and the same is discovered thereafter, termination is imminent. I authorize any of the persons or organizations referenced in this application to give you any and all information concerning my previous employment, education or any other information they might have, personal or otherwise, with regard to any of the subjects covered by this application and I release all such parties from all liability for any damages that may result from furnishing such information to you.

I authorize you to request, receive and verify all information given on this application and I release you from all liability for any damages that may result from your doing so.

I further acknowledge that if I am employed by the employer, my employment will be at will and may be terminated with or without cause at any time by me or by the employer.

I agree to conform to the rules and regulations of the employer. I acknowledge and agree that my employment and compensation can be modified or terminated at any time with or without cause and with or without notice at the option of either the employer or me. I understand that no manager or representative of the employer (other than e.g. the administrator) has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, either before commencement of employment or after I have become employed.

The above information is true and correct to the best of my knowledge. I give my permission for verification of any aforementioned factors. It is understood that any falsification will result in disqualification of my application prior to employment or immediate termination if discovered at any time thereafter. There is no contractual relationship between All Saints Home Care, Inc. and it's employees

All Saints Home Care, Inc. considers all applicants for all positions without regard to race, color, religion, sex, national origin, age, disability, veteran status or any other legally protected status.

____ ____________

Applicant Signature: Date:

AFFIRMATIVE ACTION VOLUNTARY INFORMATION

To be completed by the applicant. Not for interview purposes. To be filed separately from application. This information is used to satisfy the Affirmative Action requirements of Section 503 of the Rehabilitation Act or is necessitated by another federal law or regulation.

As required, we comply with government regulations including Affirmative Action obligations where they apply.

In an effort to comply with requirements regarding government keeping, reporting and other legal obligations, we ask that you complete this applicant data survey. Your cooperation is appreciated.

Please be advised that this survey is not a part of your official application for employment. It is considered confidential information that will not be used in any biting decision.

We consider applicants for all positions without regard to race, color, religion, sex, national origin, age, veteran status or any other legally protected status.

Position(s) applied for: ______________________________ Date:_________________

Referral Source:

[ ] Walk-in [ ] Government Employment Agency [ ] Private Employment Agency

[ ]Employee [ ] Relative [ ] School

[ ]Advertisement-Source _______________________ [ ] Other __________________

Name of person who referred you (if applicable) : _________________________________

Applicant Information

Name: ____ (____)_____________________
Last First Middle Area Telephone

Address: ____
Street City State Zip

[ ] Male [ ] Female

Please check one of the following Equal Employment Opportunity Identification Groups:

[ ] White [ ] Black [ ] Hispanic

[ ] American Indian/Alaskan Native [ ] Asian/Pacific Islander

Special notice to Vietnam era veterans, disabled veterans and individuals with physical or mental disabilities:

Government contractors subject to the Vietnam Era Veterans Readjustment Act of 1974 and the Rehabilitation Act of 1973 are required to take affirmative action to employ and advance in employment qualified disabled veterans, veterans and veterans of the Vietnam era and qualified handicapped individuals.

You are invited to volunteer this information, if you qualify, to assist in proper placement and determining reasonable accommodation. This information will be considered confidential. Refusal to provide this information will not adversely affect your consideration for employment.

If you so wish to be identified, please check any of the following that are applicable to you:

[ ] Vietnam era veteran (served between 1964-1975)

[ ] Disabled veteran

[ ] Individual with disability.

Some details you should know about home nursing care and the agency.

You are paid for:

-Visiting client's home.
-Providing thorough, proper, loving care.
-Communicating with the office about care in writing, in person and/or by phone.
-Providing documentation
-Calling for clarification of assignments
-Participation at meetings

You are required to be:

-Licensed/Certified
-Malpractice insured (LPN or RN)
-TB tested
-Disease free (infectious diseases)
-Drug Free
-Negative for history of felony offenses for 5 years

Probation lasts 90 days.

I ______________________________ understand that in the event that I am not current on any of the following: CPR license, auto insurance, driver's license, evaluation, signed care plans and TB skin test, All Saints Home Care, Inc. may hold my paycheck. I understand that my paycheck will be held until I turn in the required information. If I choose to have my paycheck direct deposited, I understand that my paycheck will be temporarily taken off of direct deposit and I will be cut a live check that will be held in the office.

____ ______________

Signature Date

FELONY DISCLOSURE

I understand that not all felony records prevent me from being employed by All Saints Home Care, Inc.

It is essential that the agency know of any past or pending convictions.

If I have failed to disclose any past or pending convictions I will be terminated when this information becomes available.

____ ________________

Signature Date

Offense	Year

PERSONAL REFERENCES

List at least three (3) persons, other than relatives, who have knowledge of your professional standards and performance.

Name Mailing Address Phone

____

____

____

____

____

In the interest of efficiency and expediency, for myself and the agency, I hereby give my permission to phone my listed references in order to obtain the data needed by the agency, on which to base their decision concerning my employability. I have provided correct telephone numbers in order to facilitate the process.

____ ______________
Signature Date

REQUEST FOR REFERENCE

I give my permission for All Saints Home Care, Inc. to request a reference from the following institution or individual.

Name of Reference or Company:_____________________
Address________________________
____
Phone________________________
Fax________________________

____ ___________________
Signature of Applicant Date

FOR OFFICE USE ONLY BELOW THIS LINE

Please speak to the following:

PROFESSIONAL ACCOUNTABILITY (PUNCTUALITY, PAPERWORK, APPEARANCE): ____
____
____
____

PROFESSIONAL SKILLS: ____
____
____
____

INTERPERSONAL SKILLS: ____
____
____
____

OTHER COMMENTS: ____
____
____

____ ___________________
Signature Date

REQUEST FOR REFERENCE

I give my permission for All Saints Home Care, Inc. to request a reference from the following institution or individual.

Name of Reference or Company:______________________
Address______________________
____
Phone______________________
Fax______________________

_______________________________________ ____________________
Signature of Applicant Date

FOR OFFICE USE ONLY BELOW THIS LINE

Please speak to the following:

PROFESSIONAL ACCOUNTABILITY (PUNCTUALITY, PAPERWORK, APPEARANCE) : ____
____
____
____

PROFESSIONAL SKILLS: ____
____
____
____

INTERPERSONAL SKILLS: ______________________________________
____
____
____

OTHER COMMENTS:____
____
____

_______________________________________ ____________________
Signature Date

AVAILABILITY

Applicants: It is very important that you complete this page in order to help us match your availability with current client needs. Be specific with times. If you are unable to work a certain day, place an "X" in the box. As soon as a possible client match is found, we will contact you.

Day	Available times
Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

Locations or areas you are willing to work:

____

____ ____________________
Signature Date

IMPORTANT INSTRUCTIONS:
Background Checks

The next 4 forms are for release to perform background checks. It is very important that they are filled out completely and correctly. **Any forms not completed or that are incorrect will be returned to the worker for recompletion. This will delay the time it takes to receive the background clearance.**

As of 1/1/2017 all personal care attendants (PCA) must pass the state mandated background checks prior to working or claiming any hours. Any personal care attendant must not have any offenses listed on the state's Prohibited Offenses List.

Any PCA with offenses on this list will be ineligible to work for the client. This list can be found at **www.kdads.ks.gov/docs/default-source/SCC-Documents/Health-Occupations-Credentialing/crc-offenses-listrevised-7-01-11.pdf?sfvrsn=0**

No hours will be paid and no time will be accepted until all the above checks are cleared and the office has informed the worker that they are eligible to work and have issued the Authenticare ID.

HEALTH OCCUPATIONS CREDENTIALING
612 SOUTH KANSAS AVE, TOPEKA, KS 66603-3856

CRIMINAL RECORD CHECK REQUEST FORM

FACILITY NAME: All Saints Home Care, Inc. **FACILITY I D # A087081**

ADDRESS:3425 W. Central Wichita, KS 67203

Applicant information: **ALL REQUESTED INFORMATION MUST BE PROVIDED** or the form will not be processed.

Last Name: First Name: Middle Name Suffix (Jr, Sr, etc)

Other Names Ever Used:

Last Name:

Last Name: **

** List additional names on back. Check here if more on back. ☐

Social Security Number Date of Birth Sex Race

One of the following **must** be selected
A - Asian or Pacific Islander
B - Black
I - Native American/Alaskan Native
W - White

Address Post Office Box # (if applicable)

City State County Zip Code

Home Phone Work Phone

Certificate # (if applicable)

Completed by Date

STATE OF KANSAS
Department for Children and Families
Prevention and Protection Services

ADULT ABUSE, NEGLECT, EXPLOITATION
CENTRAL REGISTRY
RELEASE OF INFORMATION

PPS 10400
REV 7/15

I, ______________________________ , give permission for the release of information concerning
(PRINT ONLY)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* Human Resources **Phone** 316-755-1076

Agency name All Saints Home Care, Inc.

Agency mailing address 3425 W. Central, Wichita, KS 67203

☐ **Check box if agency is a CDDO, CMHC, or ILRC**

Maiden Name and/or Other Names Known By: ______________________________
(PRINT ONLY)

Address: ______________________________
Street **City** **State** **Zip Code**

DOB: / / **SS#:** - - **Sex: M or F**
(mm/dd/yyyy) **(circle one)**

I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and the information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse and Neglect Central Registry each year while I am employed or associated with the above agency. X **Yes** _____ **No**

Signature: ______________________________ **Date:** / /
(mm/dd/yyyy)

Per statute 65-6205: Community Service Providers, Mental Health Centers and Independent Living Centers may request information for the purpose of obtaining background information on applicants for employment without signed consent. Signature is not required from the individual for which the inquiry is made.

RETURN TO:

Adult Abuse Registry
555 S. Kansas Ave
Topeka, Kansas 66603-3444

FOR PPS ADMINISTRATION USE ONLY:
Record found?

Yes ☐ **No** ☐ If yes, finding: ☐ Abuse ☐ Neglect ☐ Exploitation ☐ Fiduciary Abuse (check all that apply)

"Yes" indicates the individual is listed on the adult abuse, neglect, exploitation registry.

Perpetrator's Name: ______________________________

Region: ______________ Date Substantiated: ______________

Initial: Date:

Kansas 3rd Party Consent Form

I hereby certify that my name is ______________________________
(First Name) (Middle Initial) (Last Name)

Address ______________________________
(Street Address) (City) (State) (Zip)

Birthdate ____________ Telephone Number ______________________
(MMDDYYYY)

Driver's License Number ______________________________

Tag Number ____________________

Vehicle Identification Number ______________________________

I hereby authorize All Saints Home Care, Inc.
(First Name) (Middle Initial) (Last Name)

to obtain my vehicle registration and/or driver's license record information including my personal information on those records.

______________________________ ____________
Signature (Date)

TR-301 (Rev. 0515)

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
Child Abuse and Neglect Central Registry
P.O. Box 2637 ● Topeka, KS 66601 ● DCF.CentralRegistry@ks.gov

Release of Information

Complete form by printing legibly in ink. Fee of $10.00 per Release of Information form may be required prior to processing.

All releases and fees are to be sent to the address or email listed above (see below for specifics)

CONFIDENTIALITY: ***Kansas Department for Children and Family records are confidential. No individual, association, partnership, corporation, or other entity shall willfully or knowingly disclose, permit, or encourage disclosure of the contents of records or reports in violation of the confidentiality requirements of K.S.A. 38-2209. Violation of this statute is a class A nonperson misdemeanor and the court may impose a civil penalty of up to $1,000.***

Contact Person: ______________________ Agency/Org.: ______________________

Phone #: ______________________ Address: ______________________

Email: ______________________ City/State/Zip: ______________________

Return Results by: ☐ Encrypted email (list if different than above): ______________________ ☐ Postal Mail

Payment/Account Information (check box which applies)

☐ *Fee included*	$10 per request. Check, Money Order (payable to DCF) or cash. ***Postal mail only.***	
☐ *Online Payment**	www.dcf.ks.gov – 'Online DCF Payments' bottom of page. Payment Portal. Submit receipt with ROI form(s).	
☐ *Pre-Pay Account**	Agency/Org. has Pre-Pay Account.	FEIN:
☐ *Mentoring Account**	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/Find-a-Program	
☐ *Exempt**	No fee for State government agencies (Sub-contracting agencies not included).	

*Release of Information forms may be submitted via email to DCF.CentralRegistry@ks.gov

APPLICANT: *Instructions: PRINT CLEARLY. All requested information is required for processing. Incomplete or illegible information will result in processing delays for the Release of Information. Use 'N/A' rather than leaving a space blank.*

FIRST, MIDDLE, LAST NAME: ______________________

I give permission for the release of any of my information in the Child Abuse/Neglect Central Registry to the contact listed above. I understand the information released is for their exclusive and confidential use: ☐ *Yes* ☐ *No*

This organization/person/agency may check my information each year I am employed or associated with them: ☐ *Yes* ☐ *No*

OTHER NAMES USED: (Any/all aliases, married, maiden, nicknames, etc. 'N/A' if none used.): ______________________

DATE OF BIRTH: ______________________ **RACE:** ______________________

SOCIAL SECURITY #: ______________________ **GENDER:** ☐ *Male* ☐ *Female*

CURRENT ADDRESS: ______________________

CITY, STATE, ZIP: ______________________

PHONE: ______________________ **EMAIL:** ______________________

SIGNATURE: ______________________ **DATE:** ______________________

DCF ONLY:

MATCH		CLEARED
This applicant is listed in the Child Abuse/Neglect Central Registry. *Per KSA 65-504 and 65-516 this person prohibited from working, residing, or volunteering in a licensed child care home or facility.* (see attached document for more info.)		