Always There To Care Home Care Services, LLC
4400 Route 9 South · Suite 1000 · Freehold, NJ 07728
Phone: (732) 995·6525 · Fax: (732) 303·7342

Employment Application

Disclosure: Always There To Care Home Care Service is an equal-opportunity employer and is committed to providing a workplace free from harassment or discrimination. All employment decisions are made without regard to race, color, religion, gender, national origin, ancestry, sex, age, handicap, marital status, sexual orientation, physical or mental disability, pregnancy, military status, or any other basis prohibited by law.

Application Date: _____ Referred By: _____

First Name: _____ Last Name: _____

DOB: _____ SSN: _____

Street Address:_____

City: _____State: _____ Zip Code: _____

Home Telephone: _____ Mobile Telephone: _____

E-Mail Address: _____

Driver's License Number: _____ Expiration: _____

Car Insurance Policy Number: _____ Insurance Carrier:_____

How Many Traffic/Driving Offenses (Moving Violations) Have You Had in the past 5 years?

Please Explain: _____

_____

_____

Are You Legally Authorized to Work in the United States: Yes / No

Employment is subject to verification of U.S. citizenship or authorized alien status in accordance with the Immigration Reform and Control Act of 1986 after a conditional offer of employment is made.

Do you have Malpractice Insurance: Yes / No

Policy & Expiration Date: _____

If Hired, When Would You Be Available to Start Work: _____

If Hired, How Will You Travel to Work: _____

Do You Have an Active Health Care License in New Jersey? _____

If Yes what type: CHHA _____ CNA _____ Other_____

License Number: _____ Issued by: _____

License Expiration Date: _____ Year First Obtained: _____

How Many Hours of Training Did You Complete to Obtain Your License: _____

What Institution/Program Did You Use to Obtain Your License: _____

This position may require you to transfer up to 75 pounds of dead weight from/to a bed, commode, couch, wheelchair, etc. Are you able to perform this task? Yes / No

Are You Available for:

Hourly Care: Yes / No

Live-In Care: Yes / No

Daytime Work: Yes / No

Overnight Work: Yes / No

Are You Able to Drive Clients: Yes / No

Please write in your complete work availability. Indicate if you are available for Live-In or Hourly						
Mon	Tues	Wed	Thu	Fri	Sat	Sun

***IMPORTANT*:** All caregiver positions at Always There To Care are considered **Temporary (seasonal)** due to the frail condition of our elderly clients. Continued employment is not guaranteed for any caregiver as all employment is at-will, indefinite and not for any specific period of time. Please sign below to accept and acknowledge this condition of employment.

Applicant Signature _____ Date: _____

RECORD OF PREVIOUS EMPLOYMENT

Please note that you must provide documentation on every employer you have worked with in the past year. You must include all employers regardless of their relevance to this position. You must include all companies, private individuals and organizations with whom you worked. Please complete the list starting with your most recent employer.

Previous Employer	**Employment Period**	**Your Title or Position**
Company Name:	Start Date: _____	
Address	End Date: _____	**Primary Duties:**
City, State, Zip Code	Salary: _____	
Name and Title of Direct Supervisor	**Reason for Leaving:**	
Phone number		

Previous Employer	**Employment Period**	**Your Title or Position**
Company Name:	Start Date: _____	
Address	End Date: _____	**Primary Duties:**
City, State, Zip Code	Salary: _____	
Name and Title of Direct Supervisor	**Reason for Leaving:**	
Phone number		

Previous Employer	**Employment Period**	**Your Title or Position**
Company Name:	Start Date: _____ End Date: _____ Salary: _____	**Primary Duties:**
Address		
City, State, Zip Code	**Reason for Leaving:**	
Name and Title of Direct Supervisor		
Phone number		

I, _____ (name), hereby authorize Always There To Care to request and receive from all prior employers within one year of the date of this application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such termination.

Applicant Signature _____ Date: _____

EDUCATION AND TRAINING

High School/High School Equivalent

School Name: _____ Dates Attended: _____

Degree Obtained: _____ Major/Concentration: _____

School Address: _____

College/University

School Name: _____ Dates Attended: _____

Degree Obtained: _____ Major/Concentration: _____

School Address: _____

CPR Certification

School/Program: _____ Dates Attended: _____

Date of Issue: _____ Date of Expiration: _____

School Address: _____

Training/Certificate Programs

School/Program: _____ Dates Attended: _____

Certificate/Degree Obtained: Yes / No Skills Certified: _____

School Address: _____

School/Program: _____ Dates Attended: _____

Certificate/Degree Obtained: Yes / No Skills Certified: _____

School Address: _____

School/Program: _____ Dates Attended: _____

Certificate/Degree Obtained: Yes / No Skills Certified: _____

School Address: _____

***REFERENCES*:** Please provide at least two references. At least one reference should be a current or recent employer. References shall not include family members or personal friends. Always There To Care may contact the references provided at any time.

Reference 1 Name: _____ Dates of Supervision: _____

Title: _____ Organization: _____

Relationship: _____ Contact Phone: _____

Address: _____

Reference 2 Name: _____ Dates of Supervision: _____

Title: _____ Organization: _____

Relationship: _____ Contact Phone: _____

Address: _____

EXPERIENCE AND SKILLS

Please indicate the job skills in which you have practical experience in. For each skill you indicate, please write the date(s) in which the skill was obtained and how you obtained it.

❑Patient Positioning: _____

❑Assistance Ambulating/Walking:_____

❑Patient Transferring: _____

❑Proper Deadweight Transfer: _____

❑Hoyer Lift Transfer:_____

❑Assistance with Bedbound Patients: _____

❑Assistance with Bathing: _____

❑Assistance with Dressing:_____

❑Assistance with Toileting:_____

❑Range of Motion Exercises:_____

❑Use of a Wheelchair:_____

❑Colostomy Care: _____

❑Oxygen Tank/Administration: _____

❑Catheter Care:_____

❑Use of a Walker: _____

❑Use of a Gait Belt: _____

❑Use of a Hospital Bed: _____

❑Use of a Posey Bed: _____

❑Clients with Dementia:_____

If you have additional skills and experience that you would like to share, please use the back of this sheet. Please use the remaining space below to elaborate on your experience with older adults, and provide any other information that would be useful in considering your application.

_____

_____

_____

I hereby certify that all the information I provided is true, complete and accurate.

Applicant Signature _____ ***Date:*** _____