

KAREPRIDE LLC HOME HEALTHCARE

Please Print

Application for Employment

Equal access to programs, services, and employment is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of Karepride Llc Home Healthcare.

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 Karepride LLC? _____

Have you ever been employed Karepride before? _____

Are you legally eligible to work in the US?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 _____	

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 _____	

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.

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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 KAREPRIDE LLC's service, whenever it is discovered.

I give Karepride llc 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 Karepride llc and its representatives for seeking, gathering and using such information and all other persons, corporations or organizations for furnishing such information.

Karepride llc 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.

This application is current for only 60 days. At the conclusion of this time, if I have not heard from Karepride llc 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 must provide Karepride llc with three weeks' notice if I intend to resign at any time, with or without cause. Karepride llc reserves the 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 Karepride llc other than an authorized officer has the authority to make any assurances to the contrary. I further understand that any such assurance 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 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 _____

KAREPRIDE LLC.

Home Healthcare -----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



Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in Section 1, or specify which acceptable documentation employees must present for Section 2 or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ▼
Date of Birth (mm/dd/yyyy)		U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. An alien authorized to work until (exp. date, if any)						
If you check Item Number 4., enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the [Preparer and/or Translator Certification](#) on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

Document Title 1	List A	OR	List B	AND	List C
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

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)