

# At Ease Home Care

1430 Pearl Street  
Eugene, Oregon 97401  
Office: (541) 344-3273 Fax: (541) 744-1213  
www.ateasehomecare.com

## Caregiver Application

**Incomplete Applications Will Not Be Considered.**

**Please Read Entire Application.**

**Void 6 months after the "Date" entered below and will be shredded after 14 months.**

According to Oregon Administrative Rules, Division 536; 333-536-0050, 9, "The in home care agency must insure that a criminal background check has been conducted on all individuals employed by or contracting with the agency...." AEHC holds to the DHS guidelines ORS 443.004 regarding specific convictions that prevent them from working with an in-home care agency.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Cell Phone Carrier: \_\_\_\_\_ Email: \_\_\_\_\_

How or Who Referred You? \_\_\_\_\_ Former AEHC Employee?  Y  N

**Application at a Glance:** (Check the box: Y = Yes and N = No)

- |                                  |   |  |   |
|----------------------------------|---|--|---|
| 1) In Home Care Experience?      | <input type="checkbox"/> Y <input type="checkbox"/> N | 7) Current Drivers License?            | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 2) Elderly Care Experience?      | <input type="checkbox"/> Y <input type="checkbox"/> N | 8) Reliable Vehicle?                   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 3) ) CNA, LPN, RN License?       | <input type="checkbox"/> Y <input type="checkbox"/> N | 9) Current Automobile Insurance?       | <input type="checkbox"/> Y <input type="checkbox"/> N |
| License #: _____ Exp: _____      |   | 10) Bus / Bike / Non-Driver?           | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 5) Other Certifications: _____   |   | 11) Current TB Screening?              | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 13) Can You Pass A Drug Test?    | <input type="checkbox"/> Y <input type="checkbox"/> N | 12) Oregon Food Handler's Certificate? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 6) Do you have health insurance? | <input type="checkbox"/> Y <input type="checkbox"/> N | Through: _____                         |   |

**Skills Overview:** (Check the Box: Y = Yes and N = No, You may be asked where you received training / experience)

- |                            |   |                     |   |
|----------------------------|---|---------------------|---|
| Charting                   | <input type="checkbox"/> Y <input type="checkbox"/> N | Alzheimer's Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Gate Belt                  | <input type="checkbox"/> Y <input type="checkbox"/> N | Dementia            | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Wheelchair Transfers       | <input type="checkbox"/> Y <input type="checkbox"/> N | Hospice             | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Hoyer Lift                 | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke              | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Toilet / Incontinent Asst  | <input type="checkbox"/> Y <input type="checkbox"/> N | Wound Care          | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bathing                    | <input type="checkbox"/> Y <input type="checkbox"/> N | Cancer              | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Medication                 | <input type="checkbox"/> Y <input type="checkbox"/> N | Catheter            | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Range of Motion            | <input type="checkbox"/> Y <input type="checkbox"/> N | Colostomy           | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Developmental Disabilities | <input type="checkbox"/> Y <input type="checkbox"/> N | Mental Illness      | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Housekeeping               | <input type="checkbox"/> Y <input type="checkbox"/> N | Other: _____        |   |

**Availability:** (Check Shift Preference)  Daytime Shifts  Overnights  12-hr Shifts  24-hr

Shifts Indicate Days and Provide Times Available including am/pm: (Example: ✓ Monday: 7am-10pm)

Monday: \_\_\_\_\_  Friday: \_\_\_\_\_

Tuesday: \_\_\_\_\_  Saturday: \_\_\_\_\_

Wednesday: \_\_\_\_\_  Sunday: \_\_\_\_\_

Thursday: \_\_\_\_\_

**Education:**

High School Diploma or GED     Y     N

List College or Program Name, City and State, Dates, Subject or Degree

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**Personal References:** (Incomplete Applications will not be considered. Phone numbers must be current.)

Provide three Personal References including Name, Relationship and Reliable Phone Number. No family members or former employers.

<u>Name</u>	<u>Relationship</u>	<u>Phone</u>
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1)		
2)		
3)		

**Emergency Contact:**

<u>Name</u>	<u>Relationship</u>	<u>Phone</u>
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**Question:**

Why do you want to work as a Caregiver for AEHC and what makes you a good Caregiver?

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**Employers References:** (Incomplete Applications will not be considered.)

- Please explain gaps longer than 6 months in employment
- Provide three Employer References from the last ten years in relation to the Caregiver position you are applying for.

**Phone and Fax Numbers must be current.** Provide most recent employer first.

**Employer:** \_\_\_\_\_ **Your Job Title:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Address, City and State:** \_\_\_\_\_

**Dates Employed From:** \_\_\_\_\_ **to:** \_\_\_\_\_ **Supervisor:** \_\_\_\_\_

**Starting Wage \$** \_\_\_\_\_ **Ending Wage \$** \_\_\_\_\_

**Reason for Leaving / Are you eligible for rehire?**  Y  N

**Job Duties:** \_\_\_\_\_

**May we contact employer?**  Y  N

**Employer:** \_\_\_\_\_ **Your Job Title:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Address, City and State:** \_\_\_\_\_

**Dates Employed From:** \_\_\_\_\_ **to:** \_\_\_\_\_ **Supervisor:** \_\_\_\_\_

**Starting Wage \$** \_\_\_\_\_ **Ending Wage \$** \_\_\_\_\_

**Reason for Leaving / Are you eligible for rehire?**  Y  N

**Job Duties:** \_\_\_\_\_

**May we contact employer?**  Y  N

**Employer:** \_\_\_\_\_ **Your Job Title:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Address, City and State:** \_\_\_\_\_

**Dates Employed From:** \_\_\_\_\_ **to:** \_\_\_\_\_ **Supervisor:** \_\_\_\_\_

**Starting Wage \$** \_\_\_\_\_ **Ending Wage \$** \_\_\_\_\_

**Reason for Leaving / Are you eligible for rehire?**  Y  N

**Job Duties:** \_\_\_\_\_

**May we contact employer?**  Y  N

**Personal History:** (Provide the Following In Order to Accurately Complete Your Required Background Check.)  
List Street Addresses, Cities and States, and Dates Residing At These Locations:

Addresses

Dates

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List Other Names You Have Used and Dates You Used Them - Including Maiden Name:

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Have You Been Convicted of a Crime, Pleaded Guilty, or No Contest?  Y  N

Explain:

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**Authorization to Obtain Your Identity Verification Report / Background Check:**

I hereby certify that the answers given by me to all the questions contained on this Employment Application are true and correct to the best of my knowledge. If employed by At Ease Home Care, I will comply with all rules and regulations of the company. I agree to submit to a physical and/or drug examination if required. I have read and understand the purpose of this Employment Application. I also understand that if any fraudulent information is given on this Application it may be grounds for immediate termination from my position. I am providing complete and accurate information. Pre-employment screening fees may be applied.

I authorize At Ease Home Care to obtain an Employment/Identity Report for employment purposes. I understand that these inquiry reports may include, but are not limited to: conviction records, motor vehicle records, references, and copies of prior personnel files. I understand that providing my Social Security number and birthday is voluntary. I authorize the use of this information for the purpose of national and/or state criminal history and background checks. I understand that I may be asked to provide further proof of Identity obtained from the Social Security Department if requested. At Ease Home Care, Inc. is an Equal Opportunity Employer. I understand that the job position I am applying for is placed equally without discrimination due to race, creed, color, religion, sex, national origin, sexual preference, handicap, or age.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birthday: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

This Authorization is given pursuant to the Fair Credit Reporting Act, 15 U.S.C.1681b(b)(2)(B) .Note: The FCRA requires that an applicant must authorize in advance the procurement of an Employment/Identity Verification Report for employment purposes.

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This Authorization to Obtain Employment Verification / History must be signed before we can conduct References Checks on all Applicants.

**AUTHORIZATION TO OBTAIN EMPLOYMENT VERIFICATION / HISTORY**

I authorize my former and current employers to give any information they have regarding my employment, whether or not it is on their records, to At Ease Home Care. I hereby release At Ease Home Care and former and current employers from all liability and any damages for issuing said information.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Section 5: Completed by subject individual**

15. Name: (last, first, middle)	16. Date of birth:	17. Gender: <input type="checkbox"/> M <input type="checkbox"/> F	18. Social Security or INS number: (voluntary)
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19. All other names used: (Include maiden name.)	20. Driver's license or ID card: Number: _____ State: _____
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21. Mailing address: Street: _____ Apt: _____ City: _____ State: _____ ZIP: _____	22. Home or message phone: _____
23. During the past 5 years, have you been outside Oregon 60 days or more in a row? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list where:	
City/state/country:	From: (month/year)      Until: (month/year)

24. Street address: (if different than mailing address) Street: _____ Apt: _____ City: _____ State: _____ ZIP: _____	
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25. Have you ever been charged, arrested and/or convicted of a crime?  Yes  No  
 If you answered yes, list all charges, arrests and/or convictions (adult and juvenile) and the outcome regardless of how long ago. Attach additional pages if needed.

Date: (or estimate)	List each charge, arrest or conviction:	County:	State:	Outcome:
1.				
2.				
3.				
4.				
5.				

26. Provide a detailed explanation of all charges, arrests and convictions. (See "Questions to answer" in instructions.) This information may directly affect the outcome of this background check. Add additional pages if needed.

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I have read and understand the instructions for completing this form. I understand that a criminal records and abuse check will be completed on me and that the information may be shared with the person listed in section 1, box 1. My signature authorizes the Background Check Unit to request and receive any juvenile, police, court or investigation reports needed to complete this background check. In the event potentially disqualifying abuse is discovered, I will be notified at the address listed above and asked to provide additional information. I certify the information I have provided is correct and complete. I understand that if I provide false or incomplete information, my application may be closed or I may be denied the position. I understand the check may be repeated during the time I hold this position.

27. Signature: _____	28. Date: _____
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