American Healthcare & Family Services, LLC
847 Conners Cove
Lawrenceville, GA 30044
Phone: 404-543-3151
www.americanhealthcarefamilyservices.com

Thank you for your interest in *American Healthcare & Family Services, LLC*.

American Healthcare & Family Services, LLC provides experienced, compassionate care to seniors and their families looking for reliable, trustworthy Caregivers. We receive many inquiries each day from people who are interested in qualifying to be on our first-rate care provider team.

To be considered as a team member with *American Healthcare & Family Services, LLC*, the following must be met:

1. Minimum 1+ years of experience providing care within the industry.
2. A dependable vehicle properly insured.
3. Valid *State* driver's license.
4. You must be trustworthy and dependable.

In addition to meeting the above criteria, the following documentation will be required:

1. Recent copy of your driver's license report (within last 6 months).
2. Copy of recent TB (Tuberculosis) screening (within last 6 months).
3. Background check completed.
4. Any certifications or degrees you may have earned.
5. Minimum of 3 verifiable professional references.

If you can meet all of the above, then completely read and fill out the enclosed Application.

When you have completed the Application, please fax, return by mail or drop off at our office listed above.

Thank you for your interest.

Sincerely,

American Healthcare & Family Services, LLC

Caregiver Employment Application

By filling out this application and questionnaire, you are applying for employment at ***American Healthcare & Family Services, LLC.*** This company is dedicated to a policy of non-discrimination of applicants on any basis including race, color, age, sex, religion, disability, medical condition, national origin, or marital status.

Your Full Name			Date	
Street Address		City	State	Zip
Home Phone	Cell Phone	Tax ID / SSN #	Do you smoke? ☐ yes ☐ no	
Date of Birth:	Email address:	How did you hear about us:		

Alternate Contact

Name	Phone
Address	Relationship

Are you currently employed / provide Care to others? If Yes, Explain. ☐ Yes ☐ No Explain:

Have you ever been convicted of a misdemeanor/felony? If Yes, provide details

☐ yes ☐ no Details:

Transportation

Most clients require transportation, often using the Care Provider's vehicle:

Do you have dependable transportation? ☐ yes ☐ no		Make and model car
License plate #	Driver license #	Auto insurance policy #
Insurance company	Insurance agent name	Insurance agent phone

Availability

Appx. hours per week available:	Days/Times you **are** available	Days & times **not** available	Can you be called at the last minute in case of emergency? ☐ yes ☐ no

Which areas would you accept to work?

☐City 1 ☐City 2 ☐City 3 ☐City 4 ☐City 5

What Education Qualifies You To Work As a Caregiver?

High school	City/State	Dates
College	City/State	Dates
Other	City/State	Dates

Degrees/certificates – All Degrees / Certificates must be presented copy. All will be verified with provider/issuer.

Special skills or courses – Any skills that assist in making you qualified as a professional Care Provider.

What is Your Past Experience?

Discuss any training or experience working with the elderly. How are you trained and/or experienced in working with the elderly?

What do *YOU* do that shows and proves you're Reliable, Trustworthy and Honest?

What would you like least about working with the elderly?

Skills

Please indicate which of the following skills you are prepared to provide if referred to seniors / families:

Companion Care & Safety	☐ yes ☐ no		Medication reminders	☐ yes ☐ no		Oral Care	☐ yes ☐ no
Alzheimer's	☐ yes ☐ no		Transportation	☐ yes ☐ no		Shaving Assistance	☐ yes ☐ no
Dementia	☐ yes ☐ no		Bathing (Reg., bed, sponge)	☐ yes ☐ no		Assist w / P.T. Exercises	☐ yes ☐ no
Meal Prep / Clean Up	☐ yes ☐ no		Dressing/ Grooming	☐ yes ☐ no		Assist w/ Prosthesis	☐ yes ☐ no
Feeding	☐ yes ☐ no		Incontinence	☐ yes ☐ no		Hospice	☐ yes ☐ no
Light Housekeeping	☐ yes ☐ no		Ambulation	☐ yes ☐ no		Willing to Work w/Pets	☐ yes ☐ no
Laundry	☐ yes ☐ no		Transfer assist	☐ yes ☐ no		Speak fluent English	☐ yes ☐ no

Work History

Please provide at least five years of recent, verifiable work history followed by verifiable references.

Company	From	To

Job title	Reason left

Duties

Supervisor	Phone

Company	From	To

Job title	Reason left

Duties

Supervisor	Phone

Why Do You Feel You Would Be An Excellent Addition to Our Team?

Character, Professional, or Personal References

Name	Address	Relationship/Years Known	Local Phone #
Name	Address	Relationship/Years Known	Local Phone #
Name	Address	Relationship/Years Known	Local Phone #

CERTIFICATION AND RELEASE: I certify that I have read and understand the general requirements of Independent Care Contractors/Providers on page one of this form and that the answers given by me to the foregoing questions and the statements made by me are complete and true to the best of my knowledge and belief. I completely understand that I am submitting this Application as an interested Care Provider and that by submitting this there is no guarantee for employment. I understand that any false information, omissions, or misrepresentation of facts called for in this application may result in rejection of my application. I authorize the company and/or its agents, including consumer reporting bureaus, to verify any information including, but not limited to, work, criminal and credit history and motor vehicle driving records. I authorize all persons, schools, companies, and law enforcement authorities to release any information concerning my background and hereby release any said persons, schools, companies, and law enforcement authorities from any liability for any damage whatsoever for issuing this information.

Signature	Date

For Office Use Only – *Interview/Comments/Reference Check /Notes*

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STATEMENT OF HISTORY OF ABUSE

Read the following statements carefully and answer the question appropriately.

Have you ever been arrested or convicted of abuse or neglect of others? Yes: ____ No: _____

If yes explain: _____

_____

_____

_____

I understand my employment with American Healthcare & Family Services, LLC is TEMPORARY and terminates immediately if any criminal background check is unfavorable.

Employee's Name: _____

Employee's Signature_____

Employee's SS#: _____ Date: _____

Witness Name/Signature: _____ Date: _____

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CERTIFICATE OF ETHICAL COMPLIANCE

Employee Name: _____

Date of Hire: _____

Job Designation: _____

I am CPR & First Aid certified. I will immediately report to American Healthcare & Family Services, LLC any exposure to TB & Hepatitis B, whether the exposure occurred on or off the job.

Employee Name: _____

Employee Signature: _____ Date: _____

Supervisor: _____ Date: _____

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DRUG TESTING CONSENT FORM

I hereby consent to submit urinalysis and/or other tests as deemed appropriately by American Healthcare & Family Services, LLC in the application process for employment, for the purpose of determining the drug content thereof.

I authorize _____ to collect the specimen for the test and test the specimen for illegal drugs and release the result to American Healthcare & Family Services, LLC.

I understand that the use of illegal drugs prohibits me from becoming employed by American Healthcare & Family Services, LLC.

I further agree to release American Healthcare & Family Services, LLC from any liability arising out of the collection of specimens, testing of specimens, and any use of information from testing in connection with the employer's consideration of my application for employment.

I also agree that a copy of this Consent Form will have the same effect as the original.

I have read and I do understand the above information regarding my pre-employment substance abuse test. I agree that my signing this consent form was totally voluntary and no American Healthcare & Family Services staff coerced me into doing so.

Applicant's Name: _____

Applicant's Signature: _____

Applicant's SS#: _____ Date: _____

Witness Name/Signature: _____ Date: _____

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TUBERCULOSIS SCREENING

To prevent the transmission of tuberculosis (T.B) within the organization and the patients/community we serve, all employees must have documentation that he/she is free of communicable TB before providing services to our clients.

It is the policy of American Healthcare & Family Services, LLC that all employees are tested for the presence of inactive or active tuberculosis at the time of employment and at least annually thereafter.

Name: _____

Have you been tested for Tuberculosis? Yes: _____ No: _____

Date Tested: _____

Date read: _____

Did you do a chest X-rays: _____

Result of test: _____

I hereby certify that the above information is true and I have been informed of the agency rules:

Employee Signature: _____ **Date**: _____

Witness Name/Signature: _____**Date:**_____

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AGREEMENT REGARDING CONFIDENTIALITY, EMPLOYMENT AND NON-DISCLOSURES

This agreement regarding Confidentiality and Non-disclosure (this "Agreement), is made as of this Day of _____ 20_____, by and between American Healthcare & Family Services, LLC ("Employer") and _____ _____ ("Employee").

For and in consideration of employment by American Healthcare & Family Services, LLC and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the undersigned does hereby covenant and agree as follows;

Confidentiality Information and Non-Disclosures

A. Employee acknowledges that American Healthcare & Family Services, LLC is in the business of providing medical and in-home care and related services to individuals (the "Business") throughout the State of Georgia. Employee acknowledges that American Healthcare & Family Services, LLC business is highly specialized, that the identity and particular needs of American Healthcare & Family Services, LLC clients are not generally known in the in-home health care industry, that American Healthcare & Family Services, LLC has proprietary interest in its clients lists, and all confidential information concerning each client, and that documents and other information concerning American Healthcare & Family Services, LLC including and not limited to, its business practices, marketing strategies, sales methods, product specifications, pricing, clients identity, service location requirements, medical needs and charges to its clients are highly confidential. Employee further acknowledges that the confidential information is owned and shall continue to be owned solely by American Healthcare & Family Services, LLC.

B. During the term of employee's employment and for eighteen months (1.5 yrs) after such employment terminates for any reason, regardless of whether the termination/resignation was initiated by the Employee or American Healthcare & Family Services, LLC. Employee also agrees not to use, communicate, reveal or otherwise make available the confidential information to any person, partnership, corporation or entity other than American Healthcare & Family Services, LLC, unless such employee is compelled to disclose the confidential information by judicial process.

C. Employee also agrees that for a period of six (6) months immediately following termination of employment, regardless whether the termination/resignation was initiated by the Employee or American Healthcare & Family Services, LLC, Employee will not, for self or on behalf of any person or business enterprise, render services - Personal, Nursing or Companion care – to a person that is or was a client of American Healthcare & Family Services, LLC, that employee had provided services during employment with American Healthcare & Family Services, LLC.

Enforcement

Employee acknowledges that compliance with the agreement is necessary to protect American Healthcare & Family Services, LLC's business goodwill. A breach of this agreement will irreparable and continually damage American Healthcare & Family Services, LLC; and an award of money damages will not be adequate to remedy such harm.
Consequently, employee agrees that in the event employee breaches or threatens to breach any of these covenants, American Healthcare & Family Services, LLC shall be entitled to seek financial relief, insofar as they can be determined, including, without limitations, all reasonable cost and attorney fees incurred by American Healthcare & Family Services, LLC in enforcing the provisions of this Agreement. Nothing in this agreement however shall prohibit American Healthcare & Family Services, LLC from also pursuing any other remedy.

With your signature, you acknowledge that you have **carefully read and understand the provisions of this Agreement**, **and understand that you have the right to seek independent advice at your expense or to propose modifications prior to signing the Agreement** and have negotiated proposed modifications to the extent you deemed necessary.
Agreed to as of the first date written above.

Employee's Name: _____

Employee's Signature: _____

Employee's SS#: _____ Date: _____

Witness Name/Signature: _____ Date: _____

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STAFF CODE OF CONDUCT

Each staff member of American Healthcare & Family Services, LLC is to abide by the same code.

- Staff must respect all clients and clients' premises.
- Staff must not use client phone for personal calls.
- Staff must report all incidents/complaint to supervisor/Director.
- Staff is not allowed to smoke or drink any alcohol while on duty.
- Staff must refrain from confrontational issues while on duty.
- Staff must depart from client's home upon completion of duties.
- Staff must obtain permission from client to call Agency office.
- Staff must refrain from bringing friends or relatives to work.
- Staff must be punctual to work.
- Upon arriving at work, staff must call the office or supervisor and same when leaving. This policy of calling IN and OUT will determine your hourly pay as we do not utilize a time clock.
- Staff is not allowed to loan or borrow money from client.
- Staff must not accept any gift or gratuities from client.
- Staff must not release or talk about any client with anyone other than the supervisor of services.
- Staff must have written permission to be given a key to enter clients home. Such authorization must come from Management.
- Staff must not do anything that is outside his/her duties.
- Staff must complete all assignment before requesting client to sign or initial service forms.

Employee Name: _____

Employee Signature: _____ Date: _____

Supervisor: _____ Date: _____

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STAFF ORIENTATION

Name: _____ Date: _____

Hire date: _____ Classification: _____ SSN#: _____

Staff orientation date and Time: _____ Time completed: _____

It is the policy of American Healthcare & Family Services, LLC to make sure that every new employee complete orientation before beginning to work for us. Please use our handout to familiarize yourself with the following:

- Company Policy and Procedures.
- Client Rights and Responsibilities.
- Staff Code of Conduct.
- Confidentiality of Client files and Medical Information (HIPAA materials)
- Proper documentation of company Service Forms.
- Procedures on reporting client condition.
- Emergency procedure information forms and usage.
- Infection Control.
- Employee obligation to report known exposure from Hepatitis to TB.
- Communication Skills and Alzheimer's, Aphasia, Dementia and other related illnesses.
- Review of employee's job responsibilities.

1. My initials indicate that I have received Orientation on each of the above listed rules: (initial) _____
2. I will also provide American Healthcare & Family Services, LLC a written documentation of all training/ experience and any documented evidence of competency testing to be kept in my personnel record: (initial) _____
3. I have never been shown by credible evidence (by a Court or Jury, a department investigation, or other reliable evidence) to have abused, neglected, sexually assaulted, exploited or deprived any person, or to have subjected any person to serious injury as a result of intentional or grossly negligent misconduct as evidenced by an oral or written statement to this effect obtained at the time of this application. (initial) _____
4. All the information that I have provided is true, and any misrepresentation shall be cause for dismissal. I will abide by the terms of all the rules and codes of conduct with my position. (initial_____
5. The position is a part-time position with no guarantee of full-time hours: (initial) _____

I certify that I have completed and fulfilled all the requirements of the company's staff orientation.

Employee: _____ Date: _____

I certify that the above individual has completed and fulfilled all the requirements of the company's staff orientation.

Supervisor/Director: _____ Date: _____

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CNA /PCA SELF ASSESSMENT SKILLS

Employee _____ **Date:** _____

KNOWLEDGEABLE/SKILLS	ADULT			CHILDREN		
	Able to do	Need review	Never did	Able to do	Need review	Never did
Vital Signs:						
Temperature						
Pulse						
Respiration						
Basic Care:						
Complete Bed Bath						
Bath sponge, tub or shower						
Foot care						
Mouth care						
Hair care						
Nail care						
General Skin Care						
Decubiti Care (bed care)						
Shampoo sink, tub or bed						
Patient Positioning						
Toileting and Elimination						
Care of an incontinent patient						
Range of motion						
Make Bed						
Patient Safety:						
Wheel Chair						
Cane						
Walker						
Assist patient walking						
Transfer (bed to chair/wheelchair)						
Body Mechanics						
Patient home safety						
Special Care:						
Foley Catheter						
Condom Catheter						
Fractional Urines (S&A)						
Assist with Colostomy care						
Knowledge of low salt diet						

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CNA /PCA SELF ASSESSMENT SKILLS

Employee _____ **Date:** _____

KNOWLEDGEABLE/SKILLS	ADULT			CHILDREN		
	Able to do	Need review	Never did	Able to do	Need review	Never did
Knowledge of low cholesterol (low fat) diet						
Knowledge of Diabetic diet						
Hoyer lift						
Reinforce dressing						
Change simple non sterile dressing						
Care of paralyzed patient						
Care of handicapped patient						
Care of developmental delayed patient						
Care of Psychiatric patient						
Care of Autistic patient						
Care of elderly patient						
Care of confused patient						
Infection control						
Gloves						
Disposal of hazardous materials						
Universal precautions						
Mask						
Gown						
Charting: Read and follow plan of care:						
PSA Worksheet						
Activities Of Daily Living						
Dust and vacuum						
Wash dishes						
Clean kitchen, bedroom, bathroom						
Shop for patient						
Wash and iron clothes						
Prepare meals						
Communication With Member						
Family/caregiver						
Health Care Team						
Supervisor						

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EMPLOYMENT REQUIREMENT / DOCUMENTS

REGISTERED NURSES AND LICENSED PRACTICAL NURSES

- Georgia Nurses License (Must Verify Original Copy)
- Current BLS – American Heart Association (Must Verify Original Copy)
- PPD within the last 12 months. (Must have Documentation of Negative PPD)
- Chest X-ray within the last 5 years if PPD is positive (Proof of +PPD and CXR required)
- Drivers License (Must Verify Original Copy)
- Social Security Card, Birth Certificate or Passport.

Resume – Work experience must be current and show 5 years of relevant work history

CERTIFIED NURSING ASSISTANT

- Certified with the state of Georgia (Must Verify Original Copy)
- Current CPR – American Heart Association only (Must Verify Original Copy)
- PPD within the last 12 months (Must have Documentation of Negative PPD)
- Chest X-ray within the last 5 years if PPD is positive (Proof of +PPD and CXR required)
- Driver's License (Must Verify Original Copy)
- Social Security Card, Birth Certificate or Passport.

Resume – Work experience must be current and show 5 years of relevant work history

OTHER REQUIREMENT REQUESTED BY AMERICAN HEALTHCARE & FAMILY SERVICES, LLC

- Criminal Background Check.
- Drug Screen
- Competency Exam with a minimal of 75% score (Can only be taken 2 times)
- Three work references on file before working an assignment.