Smart Choice Home Care LLC

Caregiver Employment Application

- [ ] Current Drivers License/State Issued ID Card or Passport
- [ ] Social Security Card
- [ ] Current CPR
- [ ] Current First AID
- [ ] TB Test (within 24 months)/ Chest X-Ray
- [ ] Covid Vaccination Card (Not Mandatory)

SMART CHOICE HOME CARE LLC

Employment Application

FULL NAME: _____ DATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
E-MAIL: _____ PHONE: _____
SOCIAL SECURITY NUMBER: _____ DOB: _____
DATE AVAILABLE: _____
DESIRED PAY: $_____ ☐ HOUR ☐ SALARY
POSITION APPLIED FOR: _____
EMPLOYMENT DESIRED: ☐ FULL-TIME ☐ PART-TIME ☐ ON-CALL

EMPLOYMENT ELIGIBILITY

ARE YOU A U.S. CITIZEN? ☐ YES ☐ NO
Do you have reliable transportation? ☐ YES ☐ NO
Do you have a current CPR/First Aid Card? ☐ YES ☐ NO
Do you have a current TB Test (within the last 2 years)? ☐ YES ☐ NO
Have you ever been convicted of a Felony? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN: _____
Have you ever been convicted or charged with Medicaid Fraud or worked for an Employer that was involved/fined for such? ☐ YES ☐ NO

EDUCATION

HIGH SCHOOL: _____ CITY/STATE: _____
FROM: _____ TO: _____ GRADUATE? ☐ YES ☐ NO
COLLEGE/VOCATIONAL: _____ CITY/STATE: _____
FROM: _____ TO: _____ GRADUATE? ☐ YES ☐ NO DEGREE: _____

SMART CHOICE HOME CARE LLC

EMPLOYMENT HISTORY

EMPLOYER #1: _____
E-MAIL: _____ PHONE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
STARTING PAY: $_____ ☐ HOUR ☐ SALARY
ENDING PAY: $_____ ☐ HOUR ☐ SALARY
JOB TITLE: _____ RESPONSIBILITIES: _____
STARTING DATE: _____ ENDING DATE: _____
REASON FOR LEAVING: _____
EMPLOYER #2: _____
E-MAIL: _____ PHONE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
STARTING PAY: $_____ ☐ HOUR ☐ SALARY
ENDING PAY: $_____ ☐ HOUR ☐ SALARY
JOB TITLE: _____ RESPONSIBILITIES: _____
STARTING DATE: _____ ENDING DATE: _____
REASON FOR LEAVING: _____

REFERENCES

REFERENCE #1: _____ RELATIONSHIP: _____
COMPANY: _____ TITLE: _____
E-MAIL: _____ PHONE: _____
REFERENCE #2: _____ RELATIONSHIP: _____
COMPANY: _____ TITLE: _____
E-MAIL: _____ PHONE: _____
REFERENCE #3: _____ RELATIONSHIP: _____
COMPANY: _____ TITLE: _____
E-MAIL: _____ PHONE: _____

BACKGROUND CHECK CONSENT

IF ASKED, ARE YOU WILLING TO CONSENT TO A BACKGROUND CHECK? ☐ YES ☐ NO

DISCLAIMER

Applicant understands that this is an Equal Opportunity Employer and committed to excellence through diversity. In order to ensure this application is acceptable, please print or type with the application being fully completed in order for it to be considered.

I, the Applicant, certify that my answers are true and honest to the best of my knowledge. If this application leads to my eventual employment, I understand that any false or misleading information in my application or interview may result in my employment being terminated.

SMART CHOICE HOME CARE LLC

SIGNATURE: _____ DATE: _____
PRINT NAME: _____

SMART CHOICE HOME CARE LLC

DECLINATION FORM

The Federal Occupational Safety and Health Administration (OSHA) which address occupational exposure to bloodborne pathogens requires that vaccinations for Hepatitis B be made available to all employees who have occupational exposure to bloodborne pathogens. Smart Choice Home Care LLC will incur all cost for employees/volunteers to receive the Hepatitis B Vaccination. Prior approval is needed by Agency Director before an employee take the vaccination. I have been informed of OSHA requirements and understand the need/purpose of the vaccination, but I decline to take the Hepatitis B vaccination.

Signature: _____ Date: _____

Employee Statement of Acknowledgement

This is to acknowledge that I have received a copy of Smart Choice Home care LLC personnel policies and procedures. I understand that it provides guidelines and summary information about Smart Choice Home Care LLC personnel policies and procedures, benefits, rules of conduct. I also understand that it is my responsibility to read, understand and become familiar with, and comply with the standards that have been established. I further understand that Smart Choice Home Care LLC reserves the right to modify, supplement, rescind, or revise any provision benefit, or policy from time to time with or without notice, as it deems necessary and appropriate.

Signature: _____ Date: _____

Transportation Waiver

I consent and agree transporting of clients and family caregivers during work hours and for completing required task activities will be my sole responsibility for assuring that proper liability insurance is kept current on all vehicles use for this purpose. Further, I accept full risk of liability for any expense, damage, loss of property, or injury that may occur while transporting clients and family caregivers during approved work hours and that the agency, Smart Choice Home Care LLC will not be liable for such aforementioned conditions involving accident liabilities.

Signature: _____ Date: _____

Medication Administration

I understand that I am not to administer medication unless I have a current medication technician license issued by Maryland Board of Nursing. I also understand that I am not to administer medication unless the agency's RN has delegated the task on the Plan of Care.

Signature: _____ Date: _____

SMART CHOICE HOME CARE LLC

Employee Non-Compete Clause

I _____ understand when a client recruited by Smart Choice Home Care LLC is assigned to me and I later terminate the assignment from the agency. I cannot be placed with the client for 6 months under another working relationship. If another working relationship outside Smart Choice Home Care LLC is formed, a finder's fee of 15,000 will be deducted from what's owed and the agency will pursue legal actions to recoup whatever is owed.
Signature: _____ Date: _____

Required Employee Certifications

It is required that First Aid ($40), CPR ($40), current TB Test ($45), and Department of Public Safety Fingerprint Background Check ($35) be submitted to the office of Smart Choice Home Care LLC with qualifications.
Signature: _____ Date: _____

Property Damage and Bodily Injuries Responsibilities

I _____ consent and agree that property damages to the structure of the clients dwelling inside and outside which includes such things and is not limited to frame, windows, furniture, lawn, trees, and shrubberies are responsibilities. I further accept full responsibility and liability for any expenses, damages, losses of personal properties of client, family, friends and whosoever is present inside or outside the home which I am involved in during approved work hours. It is, also my responsibility to be accountable for any bodily injuries that may occur on my behalf to client, family, friends, and whosoever is present inside and out the home during approved work hours. Smart Choice Home Care LLC will not be liable for such aforementioned conditions involving negligence or accidents that are not covered under the company's General Liability Insurance.
Signature: _____ Date: _____

Required Drug Testing

To ensure the well-being of our clients and the proper use of techniques by our employees, we are enforcing safety within the work environment. Therefore, in case of an injury or any type of accident involving you and/or client, you are required to submit a drug test within 24 hours of the occurrence from a reputable facility as such a hospital, doctor's office, Urgent Care, and Laboratory Centers.
Signature: _____ Date: _____

Notice Of NON-Payment of Service Hours Provided to Client When Denial of Claim by Medicaid

I am hereby notified of non-payment of service hours provided by me to clients who are denied claim reimbursement from Medicaid due to hospitalization, ineligibility for service, due to Medicaid expiration, inpatient skilled nursing facility service, adult care home or any other conditions described by Medicaid to be non-refundable for Personal Care Services.
Signature: _____ Date: _____

SMART CHOICE HOME CARE LLC

Waiver Of Liability for Work Performed After Client Hours and Volunteer Services

I understand any work activities or visits performed by me after completing authorized hours according to my work schedule for clients receiving official home care/health services through Smart Choice Home Care LLC is my sole responsibility regarding any type of risk of liability that may be incurred after approved hours. Therefore, I agree that any expense, damage, accident, or loss is not the liability of Smart Choice Home Care LLC. In a volunteer capacity, the agency also is released from any expense, damage, accident, or loss that may be incurred at any time with work, activities, or visits.

Signature: _____ Date: _____

Notice of No Smoking In A Clients Home

According to the Division Of Health Services Regulations a bill was issued in effect October 1, 2007, which prohibits the smoking by employees in homes of their clients. As employees of Smart Choice Home Care LLC, you are hereby notified of this bill and required to follow this No Smoking in The Clients Home notice. Violators will be subject to disciplinary action.

Signature: _____ Date: _____

Use Of Confidential Information by Employees

I as an employee of Smart Choice Home Care LLC do hereby acknowledge that I must comply with a number of State and federal Laws which regulate the handling of confidential and personal information regarding all customers/clients of this company/Company Information and its other employees. These Laws may include, but are not limited to FACTA, The Privacy Act, Gramm-Leach-Bliley, and ID Theft Laws (where applicable). I understand that I must maintain the confidentiality of All Documents, credit card information, personal and company information of any type and that such information may be used only for the intended business purpose. Any other use of said information is strictly prohibited. Additionally should I misuse or breach, any personal information of said clients, company and or employees; I understand I will be held fully accountable both civilly, and criminally, which may include, but not limited to Federal and State fines, criminal terms, real or implied financial damages incurred by the client, employee, or this company.

Signature: _____ Date: _____