DELTA EXCELLENCE HOME HEALTH CARE, LLC

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION **DATE OF APPLICATION:** _____

Name:

_____DOB:_____

Last First Middle DD/MM/YYYY

Address:

_____

Street (Apt) City/State Zip

How long have you lived at this address?: _____

Have you been a resident of Pennsylvania for the past 2 years?: _____

Contact Information:

_____(_____)_____(____)_____

Home Telephone Mobile Telephone Email

How did you learn about our company?

_____

POSITION SOUGHT: _____ **Available Start Date:** _____

Desired Pay Range: _____ **Are you currently employed?** _____

Hourly or Salary

EDUCATION

	Name and Location	Graduate? – Degree?	Major / Subjects of Study
High School			
College or University			
Specialized Training, Trade School, etc…			
Other Education			

Please list your areas of highest proficiency, special skills or other items that may contribute to your abilities in performing the above mentioned position.

_____

_____

_____

PREVIOUS EXPERIENCE

Please list beginning from most recent

Dates Employed	Company Name	Location	Role/Title

Job notes, tasks performed and reason for leaving:

_____

_____

_____

Dates Employed	Company Name	Location	Role/Title

Job notes, tasks performed and reason for leaving:

_____

_____

_____

Authorization and Acknowledgements

I affirm that the information I have provided in this application is true to the best of my knowledge, information and belief, and I have not knowingly withheld any information requested. I understand that withholding or misstating any information requested in this application is grounds for rejection of my application, and that providing false or misleading information in this application is grounds for discharge.

I authorize the company to verify my references, record of employment, education record, and any other information I have provided. Unless otherwise noted, I authorize the references I have listed to disclose any information related to my work record and my professional experiences with them, without giving me prior notice of such disclosure. In addition, I release the company, my former employers and all other persons and entities, from any and all claims, demands or liabilities arising out of or in any way related to such inquiry or disclosure.

_____ _____

Signature Date

Delta Excellence Home Health Care requires #2 references for employment.
Delta Excellence Home Health Care will contact references given by prospective employee.
Please list reliable references as employment will not proceed until DEHHC has effectively contacted at least 2 references.

Professional References are preferred however, #1 professional reference is required.

Reference Name:_____

References Organization (if applicable):_____

Relationship to prospective hire:_____

Contact info:
Phone number: ( )_____

Address: _____

_____

Successfully contacted by DEHHC Staff:_____
Date staff signature

Reference # 2

Reference Name:_____

References Organization (if applicable):_____

Relationship to prospective hire:_____

Contact info:
Phone number: ( )_____

Address: _____

_____

Successfully contacted by DEHHC Staff:_____
Date staff signature

Have you ever been convicted of an offense listed under Act 13 that will exclude you from desired position? ____ Yes ____ No (list of offenses on previous page)

- *If answered "**No**" please continue.*

In Accordance with PA State law and Delta Excellence Home Health Care LLC policy and Procedures I, _____ give permission to Delta Excellence Home Health Care LLC to perform a Criminal History Check.

§ 52.19. Criminal history checks.

(a) The criminal history requirements in this section are in addition to the requirements in Chapter 2380 or 2390 (relating to adult training facilities; and vocational facilities), 6 Pa. Code Chapter 11 (relating to older adult daily living centers) and 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries) for providers licensed under these chapters.

(b) Prior to hiring an employee, a provider shall obtain a criminal history check which is in compliance with the following for each employee who may have contact with a participant:

(1) A report of criminal history record information from the Pennsylvania State Police or a statement from the Pennsylvania State Police that the Pennsylvania State Police Central Repository does not contain information relating to that person, under 18 Pa.C.S. Chapter 91 (relating to Criminal History Record Information Act), if the employee has been a resident of this Commonwealth for the 2 years immediately preceding the date of application.

(2) A report of Federal criminal history record information under the Federal Bureau of Investigation appropriation of Title II of the act of October 25, 1972 (Pub. L. No. 92-544, 86 Stat. 1109) if the employee has not been a resident of this Commonwealth for the 2 years immediately preceding the date of application.

(c) Criminal history checks shall be in accordance with the Older Adults Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

(d) The hiring policies shall be in accordance with the Department of Aging's Older Adults Protective Services Act policy as posted on the Department of Aging's web site at http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616725&mode=2.

(e) A copy of the final report received from the Pennsylvania State Police or the Federal Bureau of Investigation, as applicable, shall be kept in accordance with § 52.15 (relating to provider records).

I have read and understand the above stated policy. _____ (*initial)*
I understand that a felony conviction will make me exempt from this position. _____ (*initial)*
To the best of my knowledge I agree the above information is true. _____ (*initial)*

_____/ _____
Applicants Signature Date

All Employees of Delta Excellence Home Health Care must

COMPLETE AND SUBMIT below stated training Course/Test and obtain Certificate through Department of Health website:

Direct Care Staff Person Training Course and Competency Test

Complete the Direct Care Staff Person Training Course/Test

All direct care staff persons **hired after Oct. 31, 2007**, who will provide unsupervised Activities of Daily Living (ADL) services must successfully complete the course and pass the competency test in accordance with 55 Pa.Code § 2600.65(d)(2) and (d)(3) (relating to direct care staff person training and orientation). **The course/test MUST be completed prior to direct care staff persons providing unsupervised ADL services.**

Please be aware that the Department does not maintain a database of individuals who complete the course/test. Therefore, please ensure that you print out your certificate of completion before logging off, as this is the only proof provided regarding completion of the course/test.

Please also note that each individual taking the course/test must successfully log out of the course/test before another individual logs in to take the course/test. A certificate of completion will not print properly and/or be accurate if this is not done.

Please visit Link, Complete Test, Submit Certificate to Delta Excellence Home Health Care LLC Staff.

http://www.dhs.pa.gov/provider/training/personalcarehometraining/directcarestaffpersontrainingCourseandcompetencytest/index.htm

Employee SSN Verification Policy:

Delta Excellence Home Health Care LLC will operate within and in accordance with Pa code:

55 PA Code Chapter 52.11 (a)(5)(x)

Employee Social Security Number Verification.

Delta Excellence Home Health Care has chosen to verify Employee SSN from the resource listed below to verify accuracy of SSN's:

- **SSNVS**

***In accordance with** 55 PA Code Chapter 52.11 (a)(5)(x).*

I _____ hereby give Delta Excellence Home Health Care LLC permission to run my Social Security Number _____-_____-_____ through the above stated resource to ensure accuracy of the Social security number provided.

DATE OF BIRTH: ____/_____/_____

_____

Print Name

_____

Signature/ Date

Annual Training Plan

Employee Name:

_____

Job Title:

HOME CARE AIDE

Daily Responsibilities:

*Training will be performed Annually, Staff attendance will be documented sign each line

Topic		
Infection Prevention + Control		
General Principles of Cleanliness + Hygiene		
Fire Prevention + Safety		
Department-Issued policies and procedures		
Disaster Preparedness		
Resident Rights (Include DPW (Assisted Living) * look@ 201.29 state regs+MA401 * Review 483.10+483.12 of federal regs * Advanced Directives * Include personal property rights * Privacy *Preservation of dignity * Residential Confidential Information		
Prevention of Abuse and Exploitation of participants		
Dementia + Cognitive Impairment		
Provider's Quality Management Plan		
Safe Management Techniques		
Personal Care Service Needs of the Resident		
Pharmacology + Medication Self-Administration Training		
Reporting Critical Incidents		
Incontinent Care		
Nutrition * Malnutrition + Dehydration		
Fall Management		
Fraud and Financial Abuse prevention		

Signature:_____/_____

Signature/ Date (your signature confirms that you have completed and understand the above stated training topics)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is Federal legislation that created national standards to protect the privacy of patients' medical records and other personal health information.

The HIPAA Privacy & Security Regulations give patients certain rights over their health care information and requires select UC units and/or departments to put policies and procedures in place to protect patients' health information, whether oral, written, or electronic, from being used by or disclosed to individuals not authorized to access it.

HIPAA itself does not establish the regulations, but provides the framework for regulations (generally known as "rules") in four areas: transactions and code sets, identifiers, privacy, and security.

I, _____ have reviewed DEHHC HIPAA Policy.

I, _____ understand and agree to maintain patient privacy to the best of my ability under the HIPAA Guidelines.

I _____ understand that Delta Excellence Home Health Care LLC is accountable under The Health Insurance Portability and Accountability Act of 1996 (HIPAA). Client privacy is a priority to me. I, _____ will not share the client's personal information outside of Delta Excellence Home Health Care scope of practice.

_____

Print Name

_____

Signature/ Date

I, _____ have read and understand The Delta
(Print Name)
Excellence Home Health Care Policy Manual. I am aware of how to access the policies when needed for reference or practice. I am aware that my signature also represents my cooperation in following all of Delta Excellence Home Health Care's Policies to the best of my ability.

_____

Print Name Date

_____

Signature Date

MANTOUX PPD TEST

A 2-step PPD is required for all new hires. Documentation of a 2-step within the prior 12 months is also acceptable. Please make sure to read the below statement regarding the required time interval between the 1st and 2nd injections; if your 2-step does not follow this, it will be rejected. A 1-step PPD is required yearly thereafter

I. Patient Information

Last Name First MI D.O.B. Social Security Number

II. Required Tuberculosis Test Results (as per Regulations of the Department of Health)

1st Step

Date Applied	Arm	Method	Antigen	Manufacturer	Signature & Title

Date Read	Results (mm)	Signature & Title

If 1st step is negative, the 2nd injection should be administered **no earlier than 7 days** and **no later than 21 days** after the ***READ DATE (not place date)*** of the 1st injection.

2nd Step

Date Applied	Arm	Method	Antigen	Manufacturer	Signature & Title

Date Read	Results (mm)	Signature & Title

Chest X-Ray: is ***only*** permitted if you have had a prior +PPD. For previously known/new positive reactors please complete the following and ***submit a copy of the chest x-ray report*** completed within the last 5 years that states the results are clear from infectious or contagious diseases. ***This report must state that the reason for the CXR is due to a +PPD***.

Chest X-ray: Date:_____ Results:_____ **Other:** Date:_____ Results:_____

New Employee Checklist

Document	INITAL	Date Completed	Staff Initial/ Date
Application			
Criminal Background Check			
W4 Form			
I-9 Form			
Training Certificate (DHS)			
SSN Number Verification Form			
Annual Training (initial and sign)			
HIPAA Commitment			
Review & Sign DEHHC LLC Policy Manual			
CPR Certification (optional)			
Copy of (2) ID, SS Card, Birth Cert or Passport			
2 step PPD			
2 References			
Staff Use Only:			
Employee contact info added to list			
PPD/ Training dates filed			
Face to face interview			
References contacted			
Medi-Check			

Please Return to Office with Completed Material as this will become part of your File

Staff Use Only!

Overview of Interview

Qualifications/Skill Level:

_____
_____
_____
_____
_____

Impression of Applicant:

_____
_____
_____
_____
_____

Availability:

_____
_____
_____
_____
_____

_____

Signature:

_____

Date/ Time: