Preferred client First & Last Name:
_____

Direct Home Health Care Inc.
1622 Park Avenue South♦ Minneapolis ♦ MN 55404
Phone: 612-870-8256 ♦ Fax: 612-870-1968 ♦ www.directhomehealthcare.com

Application for Employment

Employees of Direct Home Health Care, Inc. and applicants for employment shall be afforded equal opportunity in all aspects of employment without regard to race, color, religion, political affiliation, national origin, disability, marital status,

Gender or age. As a means of accommodation to persons with specific disabilities that prevent them from completing this application, confidential assistance in filling out this application may be obtained by contacting our office.

Position Applied For:_____

Applying For: ☐ **Full-Time** ☐ **Part-Time** ☐ **Temporary**

PERSONAL INFORMATION			
***First Name (complete)**	***Middle Name (complete)**	***Last Name (complete):**	
***Social Security Number** (Note: Social security number & D.O.B is required on background check forms prior to employment.) : - -	**D.O.B MM/DD/YYYY** ___ /___/____	***State You Were Born:**	**E-Mail Address (optional)**
***Current Residing Address**			
***City:**	***State:**	***Zip Code:**	**County:**
***Home Phone Number:**	**Cell Phone Number:**		
***Mailing Address if different from residing address listed above.**			
***Driver's License or State ID Information:** ***State:** ***ID Number:** ***Expiration Date:**			
***Weight:**	***Hair color:**	***Eye color:**	***Sex:** Male Female

Please list previous address in the last 5 years if different from current residing address:
2016:
2015:
2014:
2013:
2012:

Who should be contacted if you are involved in an emergency?

EMERGENCY CONTACT			
Name (FIRST, LAST):			
Relationship	**Phone Number**		
City:	**State:**	**Zip Code:**	**County**
Name (FIRST, LAST):			
Relationship	**Phone Number**		
City:	**State:**	**Zip Code:**	**County**

***Are you known by any other names or aliases**
1.
2.
3.
4.
5.

ADDITIONAL INFORMATION

Who referred you to our company? _____

How did you find out about this employment opportunity? _____

*** Do you own or have access to reliable transportation? ☐ YES ☐ NO**

***For purposes of compliance with the Immigration Reform and Control Act, are you legally eligible for employment in the United States? ☐ YES ☐ NO**

UNDER THE IMMIGRATION REFORM AND CONTROL ACT OF 1986, YOU WILL BE REQUIRED TO FILL OUT A CERTIFICATION VERIFYING THAT YOU ARE ELIGIBLE TO BE EMPLYED AND VERIFYING. FUTHER, YOU WILL BE REQUIRED TO PROVIDE DOCUMENTATION TO THAT EFFECT SHOULD YOU BE EMPLOYED.

***If hired, can you present evidence of your U.S. citizenship or proof of your legal right to work?**
☐ YES ☐ NO

***Have you ever been arrested or convicted of a crime in the past 5 years? ☐ YES ☐ NO**
If yes, please explain why:

_____

_____

*** Which shift will you be available to work? ☐ Day ☐ Evening ☐ Night**

***If you are offered employment, when would you be available to begin work? _____**

Salary desired? _____

***What languages do you speak, write, or understand?**
(WRITE DOWN RATING 1-5, MEANING 1=POOR, 2=BELOW AVERAGE, 3=AVERAGE, 4=ABOVE AVERAGE, 5= EXCELLENT)

LANGUAGE	*SPEAK*	*WRITE*	*UNDERSTAND*

EDUCATION

SCHOOL	*NAME, ADDRESS, CITY, STATE, ZIP*	*# YEARS COMPLETED*	*DID YOU GRADUATE?*	*DEGREE OR DIPLOMA*
High School			☐Yes ☐No	
College/University			☐Yes ☐No	
Graduate School			☐Yes ☐No	

WORK EXPERIENCE

Use Supplementary Experience Form(s) for additional space. Starting with the most recent, describe ALL paid, military and applicable voluntary experience. Highlight your knowledge, skills and abilities which best demonstrate your qualification for this position. You may list significantly different jobs within the same organization as separate items.

Employer	**Job Title**
Address	
Supervisor Name	**May We Contact Them?**
Phone Number	**Salary**
Responsibilities	
Reason For Leaving	
Employer	**Job Title**
Address	
Supervisor Name	**May We Contact Them?**
Phone Number	**Salary**
Responsibilities	
Reason For Leaving	
Employer	**Job Title**
Address	
City, State, and Zip Code	
Supervisor Name	**May We Contact Them?**
Phone Number	**Salary**
Responsibilities	
Reason For Leaving	

List three persons that are NOT related to you, and who can furnish information about your job performance. All three should be professional references.

REFERENCE	
Name	**Relationship**
Address	
Phone Number	**Number of Years Known**
Company	**Occupation**
Name	**Relationship**
Address	
Phone Number	**Number of Years Known**
Company	**Occupation**
Name	**Relationship**
Address	
Phone Number	**Number of Years Known**
Company	**Occupation**

**** Please provide any other information that you believe should be considered:***

_____

_____

_____

_____

_____

_____

*Pursuant to federal regulations, we collect responses to the questions below for record keeping purposes. This optional information will **NOT** be kept with your application for employment.
Federal law prohibits unlawful discrimination on the basis of race, color, sex, age, national origin, religion, or disability. Check the block for the racial or ethnic group with which you identify:

- ☐ White (includes Arabian)
- ☐ Black (includes Jamaican, Bahamians and other Caribbean's of African but not Hispanic or Arabian descent)
- ☐ Hispanic (includes Mexican, Puerto Rican, Central or South American or other Spanish origin)
- ☐ Asian or Asian American (includes Pakistanis, Indians, and Pacific Islanders)
- ☐ American Indian (includes Alaskans)

*Check the appropriate block:

- ☐ Female
- ☐ Male

***CERTIFICATION**

Each Application Requires Current Date and Original Signature

I hereby certify that all and attachments are true and complete, and I agree and understand that any falsification of information herein, regardless of time of discovery, may cause forfeiture on my part of any employment in the service of the Direct Home Health care, Inc. I understand that all information on this application is subject to verification and I consent to criminal history background checks. I also consent to references and former employers and educational institutions listed being contacted regarding this application. I further authorize the Direct Home Health Care, Inc. to rely upon and use, as it sees fit, any information received from such contacts. Information contained on this application may be disseminated to other agencies, nongovernmental organizations or systems on a need to know basis for good cause shown as determined by the agency head or designee.

Print Full Name: _____ Date:_____
(MM / DD / YYYY)

Employee Signature: _____

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PCA/Employees cannot work more than 275 hours per month total. Hours worked for any agency will count toward the monthly total, which equals more than 9 hours a day.

I, _____ Agree and Understand
(Print Employee Name 'PCA')

that I will not work more than 275 hours per month including any hours worked for any other agency. I understand that if I am affiliated with more than one agency, I am responsible for monitoring my hours and informing Direct Home Health Care of my affiliation with more agencies. I understand that I will have to pay back if I exceed these hours.

_____ _____

Employee Signature Today's Date

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Hennepin County / State Guidelines

I, _____ Agree and Understand
(Print Employee Name 'PCA')

that I can only work the amount of hours that are assigned on the care plan unless I'm told otherwise. The State requires all PCA to follow the assigned instructions that the care plan states.

_____ _____

Employee Signature Today's Date