Dear Caregivers,

Welcome to EldersChoice! This is the Application Form for EldersChoice, Inc. (Pennsylvania), EldersChoice of Maryland, and EldersChoice of Connecticut. You only need to fill out ONE application to be eligible to be a caregiver in all three states – complete every page.

EldersChoice is a referral agency that offers only 24/7 live-in care provided by trained certified nursing assistants and home health aides (also known in some states as state tested nursing assistants) to perform homemaking, companionship and personal care services. As a referral agency, we recruit, screen, compile your information, and refer you to clients and families for live-in work. EldersChoice also provides care planning and case management services to all of our clients and families.

There are several forms that need to be filled out. Please refer to the instructions on the next page that shows what you must send to EldersChoice in order to be referred to a case. EldersChoice requires a current physical from a licensed medical professional and may require your doctor to confirm that you are able to perform your work duties. Please make sure all health forms are signed and dated by a licensed health care professional. You may use our Caregiver Health Form or other health physical form. EldersChoice also requires that all caregivers working directly with clients have an updated TB test. If the TB test is positive, a chest x-ray is required. You may use our PPD form or similar form from your healthcare provider.

When we meet you, EldersChoice requires caregivers to show two picture identifications, such as a passport, valid driver's license, state identification, or a valid permanent resident card with authorization to work. We also require a valid social security number. Please send copies of these documents with your application. Also, please send a copy of your HHA or CNA license or certificate of training and provide two recent job related references. References cannot be from your own family members or friends; we will check your references. EldersChoice must perform background checks on all caregivers and we pay this cost. EldersChoice will report any caregiver suspected of identity fraud.

All referred caregivers work directly for the client and not for EldersChoice. EldersChoice suggests daily rates to clients and families for direct care workers are $140 per day and higher, based on the needs of the client. Rates caring for a couple are higher. In addition, caregivers should receive time and a half their normal rate for major holidays, and food money. EldersChoice does not decide your pay or pay you any money or benefits, such as taxes, insurance, workers' compensation or unemployment compensation. As a direct care worker, the payment of and provision for taxes and any benefits are between you and the client/family.

All caregivers must have an interview before they are referred to a client living in a home or independent retirement community. There will be no interviews or referrals to any case until caregivers send all the necessary documentation with their application. We will not process incomplete applications and will destroy incomplete applications 30 days after receipt.

EldersChoice is an equal opportunity organization. EldersChoice does not discriminate in referrals or placement on the basis of race, sex, color or national origin, ancestry, religious creed, handicap or disability and age.

PLEASE FILL OUT THE APPLICATION AND FOLLOW

THE MAILING or FAX INSTRUCTIONS ON THE NEXT PAGE

To All Caregivers:

Please send the following copies along with your application to EldersChoice:

1. Picture Identification for Non-Driver's or a Driver's license
2. A valid Passport, Permanent Resident Card, or Naturalization Certificate
3. Social Security Card with "Work Authorization"
4. Copy of Certification of Training and/or License (CNA/HHA/PCA/STNA/LPN)
5. Copy of negative TB (PPD) test within a year or a normal chest x-ray which is valid for five years
6. A physical performed within the last 12 months signed and stamped by your doctor or other licensed health professional. You do not have to use EldersChoice forms for PPD and physical if you already have these papers from your doctor. You may use our two forms enclosed with the application if you need to get a new TB test and physical.
7. Complete, sign and date the Authorizations for Criminal Background Check for Connecticut, Maryland and Pennsylvania. EldersChoice conducts national and state background checks and when applicable, FBI fingerprinting. Drug testing also may be a requirement in some states and cases. These items are required to be eligible for referral to any of EldersChoice location.
8. Only sign and date the reference sheets provided. Do not write references on these sheets. EldersChoice will use the space to document your information from two previous employers – not friends or family. Also, make sure that you write the names, address and phone numbers from your previous jobs on the "EldersCholce Caregiver Informational Form" located in the application packet. EldersChoice will only accept references from hospitals, nursing homes/rehabilitation facilities, nursing and hospice agencies, other home care agencies, group homes or private cases.

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED & DESTROYED IN 30 DAYS

Thank you for your cooperation,

EldersChoice Human Resource Department

Please Mail Or Fax This Application To ONE Of The Locations Below.

NOTE: This is a Fillable PDF. You can complete this form on your computer for many fields.

You can save and return to edit. When you're satisfied, print this form and complete the remaining fields by hand.

EldersChoice. Inc.	EldersChoice of Maryland, LLC	EldersChoice of Connecticut, LLC
P.O. Box 61122	3681 Ashley Way	P.O. Box 370361
Harrisburg, PA 17106-1122	Owings Mills, MD 21117-1435	West Hartford, CT 06137-0361
Fax: 717-541-8295	Fax: 410-363-6795	Fax: 860.523.8400

ElderChoice Caregivers Informational Form

Name: _____

Mailing Address:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth (mm/dd/yyyy): _____ Social Security Number:_____

Passport, Green Card or Long Term Visa Number:_____
(Please provide copy of passport or Green Card)

Work Permit? Yes ◯ No ◯ EIN Number: _____
(Connecticut only)

Driver's License (if you have one): State: _____ Number: _____
(Please provide copy of Driver's License)

Emergency Contact Person:_____

Telephone:_____

List work experience in the past three years:

Name of Business or Supervisor:_____
Address:_____
State and Zip Code:_____ Telephone:_____
How long did you work there?_____

Name of Business or Supervisor:_____
Address:_____
State and Zip Code:_____ Telephone:_____
How long did you work there?_____

Two work related references - NOT FAMILY OR FRIENDS

Name:_____ Name:_____

Telephone number:_____ Telephone number:_____

Have you had a physical completed by a physician in the last 12 months? Yes ◯ No ◯

If yes, please attach a copy. If no, you must get a physical in order to be referred by EldersChoice. The enclosed Caregiver Health Form must be completed or you must provide a copy of a physical from your physician. If physical is not current, it is the responsibility of the caregiver to update this information. If information is not updated the caregiver cannot be placed.

Have you had a TB test with the last 12 months? Yes ◯ No ◯

If yes, please attach a copy or provide evidence of a normal chest x-ray from your physician. If No, attached is a sample TB (PPD) Test form. You can use this form or provide results from your physician.

Do you have any physical limitations (lifting, transferring, food allergies, etc.) that would prohibit you from caring for a client? Yes ◯ No ◯

Educational Background (please list and provide copies of any special training or certificates)

_____

_____

_____

Work Background (please use a separate sheet of paper for additional information if necessary)

_____

_____

_____

Please list any languages you speak in addition to English? _____

Signature of Caregiver:_____ Date:_____

Print Name:_____

Date can start work:_____

References checked:_____

CAREGIVER HEALTH FORM

[You can use a form from your Doctor]

The top portion is to be completed by Caregiver

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
◯	◯	Diabetes	◯	◯	Shortness of Breath	◯	◯	Hospitalized
◯	◯	Heart Disease	◯	◯	Epilepsy/Seizures	◯	◯	Mental Disorder
◯	◯	Hepatitis A	◯	◯	Hepatitis B	◯	◯	Asthma
◯	◯	Stroke	◯	◯	Back/Spinal Problems	◯	◯	Salmonella
◯	◯	Shigella	◯	◯	Shiga toxin producing	◯	◯	Escherichia coli

If you answered YES to ANY of the questions about, please explain:

_____

Do you have <u>any</u> other conditions which might cause risk to a client or could potentially interfere with the performance of one's duties, including the habituation of alcohol or current addiction to depressants, stimulants, narcotics, or any other substances? YES ◯ NO ◯

Please explain _____

I certify that the above statements are true and correct. If it is later found that the information is untrue, incomplete or misrepresented, I understand and agree that EldersChoice is relieved of all commitments, financial or otherwise and that I am subject to immediate termination.

_____ _____

Caregiver Signature Date

<u>CAREGIVER HEALTH EXAMINATION</u>

TO BE COMPLETED, SIGNED, DATED AND ***STAMPED*** BY PHYSCIAN

Blood Pressure_____ T_____ P_____ R_____ Height_____ Weight_____

Ears _____ Abdomen _____ Hernia _____ GI History _____

Eyes_____ Skin _____ Heart _____ GU History _____

Nose _____ Throat_____ Lungs_____ Extremities _____

_____ _____

Physician/PA/APRN/Nurse Practitioner . Date

PPD FORM

[REQUIRED IF YOU CANNOT PROVIDE A NORMAL CHEST X-RAY WITHIN THE LAST 5 YEARS]

SECTION I: (to be completed by Direct Care Worker)

Last Name:_____ FirstName: _____ MI: _____

Social Security Number: _____

Telephone:_____

SECTION II: (to be completed by Health Care Professional)

Provider Name: _____

Address: _____

_____ Phone: _____

Tuberculosis Screening (PPD) – Step 1	Tuberculosis Screening (PPD) – Step 2
Date Given: Time:	Date Given: Time:
Manufacturer:	Manufacturer:
Lot:	Lot:
Expiration Date:	Expiration Date:
Dosage: Route:	Dosage: Route:
Arm: L R	Arm: L R
Signature:	Signature:

SECTION III: To be completed if 10mm or greater

1. Attach copy of Chest X-ray report
2. Is the Applicant free of infectious Tuberculosis Disease? Yes No
3. Was the Applicant referred for treatment? Yes No
   If Yes, when, where and what is treatment
   _____
4. Was BCG given? Yes No
   If Yes, when was it given?
   _____

CAREGIVER REFERENCES

Please only sign and date this form

Caregiver Name:_____

SSN:_____

Employer: _____

Job Description:_____

Please list start and end date of employment: _____to_____

Is _____ eligible for rehire? Yes No

Comments if possible:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I give EldersChoice permission to check my previous employment references.

_____ _____

Signature of Caregiver Date

Print Name _____

CAREGIVER REFERENCES

Please only sign and date this form

Caregiver Name:_____

SSN:_____

Employer: _____

Job Description:_____

Please list start and end date of employment: _____to_____

Is _____ eligible for rehire? Yes No

Comments if possible:

_____

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_____

_____

I give EldersChoice permission to check my previous employment references.

_____ _____

Signature of Caregiver Date

Print Name _____

CAREGIVER REFERENCES

Please only sign and date this form

Caregiver Name:_____

SSN:_____

Employer: _____

Job Description:_____

Please list start and end date of employment: _____to_____

Is _____ eligible for rehire? Yes No

Comments if possible:

_____

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_____

_____

I give EldersChoice permission to check my previous employment references.

_____ _____

Signature of Caregiver Date

Print Name _____

Connecticut Authorization
Submission of Criminal Background Check

In accordance with Chapter 400o, Section 20-678 of the Connecticut General Statutes, Homemaker and Companion Agencies are required to conduct a comprehensive background check of all caregivers. In addition, prospective caregivers are required to reply to the following questions:

1. Have you ever been convicted of a crime involving violence or dishonesty in a state court or federal court in any state? Yes ○ No ○

2. Have you ever been subject to any decision imposing disciplinary action by a licensing agency in any state, the District of Columbia, a United States possession or territory or a foreign jurisdiction Yes ○ No ○

EldersChoice will not refer any caregiver who has a history of elder abuse or criminal background.

I hereby certify that the statements made by me on this application are true and complete to the best of my knowledge and are made in good faith. Further, I authorize EldersChoice of Connecticut, LLC to conduct a comprehensive background check. I understand that if I knowingly make any misstatements of fact, I am subject to disqualification and dismissal and to such other penalties as may be prescribed by law or EldersChoice policy and procedure.

As sworn by me this_____day of_____20____

Signature Print Name

WITNESSED

Signature Print Name

Name: _____

Pennsylvania Authorization
Submission of Criminal Background Check

The Older Adults Protection Service Act of Pennsylvania Act 13 and Act 14 prohibits hiring of individuals to a skilled Nursing Facility, Personal Care Home, Home Health Agency or enrolling in a Nurse Aide training program who have in their lifetime been convicted of one of the following crimes:

* Aggravated Assault
* Arson
* Burglary
* Criminal Homicide
* Concealing the death of a child
* Dealing in infant death
* Endangering the welfare of children
* Forgery
* Felony theft or 2 or more misdemeanor thefts
* Incest
* Indecent Assault
* Kidnapping
* Intimidation of victim or witness
* Indecent Exposure
* Involuntary Deviate Sexual Intercourse
* Murder
* Obscene & other Sexual Materials and performances
* Prostitution
* Rape & Sexual Assault
* Retaliation against Victim or Witness
* Robbery
* Securing the execution of documents by
* Sexual Assault
* Deception
* Organized Retail Theft
* Sexual Abuse of Children
* Unlawful Restraint

In signing below, you are attesting that you have not been convicted of any crime listed above in your lifetime. In addition, your signature below serves as your permission to permit your name to be submitted to the Pennsylvania State Police Criminal Background Check System* and/or background check through the FBI.

Please answer the following questions:

Name (Print First, Middle, Last):_____

Other names used (including Maiden):_____

Valid driver's license or state-issued ID card: State ____ #_____ Valid thru: _____

State in which you currently are a resident: _____

If outside of PA, have you ever lived in PA: Yes ◯ No ◯ If yes, for how long: _____

Current Address: _____

Number of years at this address: _____

Prior address if less than 2 years at current: _____

_____ _____

Signature Date

Maryland Authorization
Submission of Criminal Background Check

In accordance with Health - General Article Title 19, Subtitle 4B, Article 03(c) under the Annotated Code of Maryland, EldersChoice is required to perform a state criminal history records check or a private agency background check.

EldersChoice will neither refer nor contract with an individual who has a history of elder abuse or criminal background.

In signing below, you are attesting that you have not been convicted of any crime in your lifetime. In addition, your signature below serves as your permission to submit your name to be submitted for a State criminal history records check or a private agency background check.

_____ _____

Signature Date