BETHESDA ELITE CARE, INC.

EMPLOYMENT APPLICATION

FOR OFFICE USE ONLY: Hire Date: _ / _ / __

Please Print clearly. This application must be completed and all questions regarding your training and work experience answered. All information on the application is confidential. BETHESDA ELITE CARE, INC. will not contact your present employer without your consent.

Name: (Last) (First) (Middle initial)

Other Name: (if applicable) **Social Security #:**

Current Address: (Apt. #)

City: **State:** **Zip Code:** **Length of time at this address:**

Previous Address: (Apt. #)

City: **State:** **Zip Code:** **Length of time at this address:**

Home Phone: ( ) **Cell Phone: ( )** **Other Phone: ( )**

U.S. Citizen: ❑ Yes ❑ No - If no, Immigrant ID/Card: **Expiration Date**

Position Appling for: ❑Admin. ❑ RN ❑ LPN ❑ HHA ❑ PCA ❑Homemaker ❑ PT/OT/RT ❑ MSW ❑ Clerical ❑ Other

Minimum Salary Requirement: **Date Available To Begin:**

Days Available To Work: (Check all that apply) ❑Sat ❑Sun ❑ Mon ❑ Tues ❑ Wed ❑Thu ❑ Fri

Hours Available To Work: (Check all that apply) ❑ 4 hours AM ❑ 4 hours PM ❑ 8 hours ❑ 12 hours AM ❑ 12 hours PM ❑ Live In

Which Languages can you speak: (Check all that apply) ❑ Spanish ❑ Russian ❑ Polish ❑ Hebrew ❑ Yiddish ❑ Hungarian ❑French ❑ Other (specify)

EDUCATION/SCHOOLS ATTENDED	NAME OF SCHOOL AND ADDRESS	DID YOU GRADUTE	COURSE OF MAJOR	DIPLOMA OR DEGREE	YEAR COMPLETED
HIGH SCHOOL					
COLLEGE					
GRADUTE SCHOOL.					
BUSINESS SCHOOL					
TRAINING PROGRAM					

WORK HISTORY

Name, Address and Phone # of Current/Former Employers	From: Mo/Yr	To: Mo/Yr	Job Title	Supervisor's Name	Salary	Reason for leaving

ADDITIONAL REFERENCES:

NAME	ADDRESS / PHONE#	RELATIONSHIP

AVAILABILITY

APPLYING FOR ☐ FULL TIME ☐ PART TIME	HOURS AVAIL.	M	T	W	T	F	S	S
IF PART TIME ☐ DAYS ☐ EVENINGS	FROM							
TOTAL HOURS AVAILABLE PER WEEK:	TO							

WILL YOU WORK OVERTIME IF REQUIRED? ☐ YES ☐ NO IF NO, PLEASE EXPLAIN _____

POSITION DESIRED	**SALARY DESIRED**	DATE YOU CAN START

Have you ever been bonded? ☐ **Yes** ☐ **No - If Yes, by Whom:**

Have you ever been refused a bond? ☐ **Yes** ☐ **No - If Yes, by Whom:**

Have you ever been convicted of a crime? ☐ **Yes** ☐ **No - If Yes, Explain:**

Professional Licenses:

Profession: **Lic. No:** **Exp. Date:** **Verification:**

Professional Licenses:

Have you ever been sanctioned by Medicare/Medicaid ☐ **Yes** ☐ **No**

Para-Professional certification: ☐ **HHA** ☐ **PCA**

School/Training Program: **Verification:**

Para-Professional Certification: ☐ **HHA** ☐ **PCA**

School /Training Program: **Verification:**

The information listed in my application is complete and true. I understand that if employed false statements on this application are cause for dismissal. I will comply with all of the agency's rule and regulations regarding my employment. BETHESDA ELITE CARE, INC. May request information regarding my background which will include work and personal references.

Applicant's Signature **Today's Date**

BETHESDA ELITE CARE. does not discriminate because of sex, age, physical handicap, race, creed or national origin. The agency is an equal opportunity employer.

Title: **Starting Salary:**

IF HIRED: COMPLETE THE FOLLOWING

Date of Orientation: Date of Hire: Starting Date:

Title: Starting Salary:

REFERRAL SOURCE

☐ Walk-in ☐ Government Employment Agency ☐ Private Employment Agency

☐ Employee ☐ Relative ☐ School

☐ Advertisement- Source_____ ☐ Other_____

Name of person who referred you IF APPLICABLE _____

For Administrative Use Only

Position(s) applied for ☐ Available ☐ Not Available

Other positions considered for

_____

Hired ☐ Yes ☐ No

Position hired for _____ Date of hire _____

From the EEO job classifications listed below, which one best describes the position filled?

☐ Officials and Managers ☐ Sale Workers ☐ Operatives (semi-skilled)

☐ Professionals ☐ Office and Clerical Workers ☐ Laborers (unskilled)

☐ Technicians ☐ Craft Workers ☐ Service Workers

Notes_____

_____

Completed by_____Date_____

I certify that the information given by me is true and correct and without any omission. I understand and agree that any false statement or intentional omission on this application or any subsequently furnished from constitutes cause for discharge at any time during my employment by Bethesda.

I authorize Bethesda Elite to investigate all statements made in this application. I further authorize Bethesda Elite to make any investigation of my credit, criminal and driving records in connection with this application and anytime thereafter in connection with my employment.

I authorize the references listed in this application, to provide Bethesda Elite will all information concerning my previous employment and any other pertinent information about me that they may have.

I understand that all information obtained during pre-employment screening is held by Bethesda Elite in confidence and will not be released to a third party unless Bethesda Elite is required by law or is specifically authorized to do so by me. I further understand that if I am hired, I will not have an employment contract and that my employment and compensation can be changed or terminated with or without notice or cause at any time by Bethesda Elite or by me.

Signature: _____

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

NYS Department of Health, Criminal History Record Check Unit

chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

Last Name	First Name	Middle Initial	Maiden Name

Date of Birth (mm/dd/yyyy)	Alias/AKA	Mother's Maiden Name

Mailing Address (street)	City	State	ZIP Code

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary. In accordance with applicable laws, DOH will furnish appropriate summary information to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for any non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.

NYS Division of Criminal Justice Services
Criminal History Bureau
Record Review Unit-5th Floor
4 Tower Place
Albany, NY 12203
(518) 485-7675

Federal Bureau of Investigation
Criminal Justice Information Services
(CJIS) Division
1000 Custer Hollow Road
Clarksburg, WV 26306

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7. I certify to the best of my knowledge and belief that I (check as appropriate):
   - ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
   - ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you checked either "Have" and/or "Do", please provide a brief explanation. (Optional)

   _____
8. My current mailing or home address is indicated in Section 1 of this form.
9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own.

Applicant Signature: _____ Date: ____/____/_____

Name and Signature of Parent or Legal Guardian: _____ Date: ____/____/_____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	Operating License Number (PFI):
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

This form is to be retained by the agency. Do not forward to the DOH CHRC Unit.

NYS Department of Health | CRIMINAL HISTORY RECORD CHECK

Resubmission ○

Type or print all information - USE CAPITAL LETTERS.
Inaccurate, incomplete or illegible information will delay processing.

DOH use only. Leave blank

SECTION 1 - SUBJECT INDIVIDUAL INFORMATION

Social Security Number* ___ - ___ - ____

Date of Birth mm/dd/yyyy ___ / ___ / ____

LAST Name

FIRST Name

M.I.

Maiden Name

Alias (AKA)

Street Nmbr

Street Name

City

St

Zip

Apt #

Sex

Race

Birth Country/Place

Height (ft-inch) ___ - ___

Weight (lbs)

Hair

Eyes

Home Phone ___ - ___ - ____

Cell Phone ___ - ___ - ____

SECTION 2 - SUBJECT INDIVIDUAL IDENTIFICATION

Please Select the Type of **PICTURE IDENTIFICATION** (select one):

○ Drivers License/ DMV ID ○ Passport ○ Military ○ School ○ Other Identify:

Issuing State/Country/Armed Force/School:

ID Number

ID Expire Date mm/dd/yy ___ / ___ / ___

SECTION 3 - AGENCY IDENTIFICATION

○ Nursing Home ○ CHHA ○ LTHHCP PFI#

○ LHCSA LICENSE #

Full name of Agency where applicant will be working

Telephone number with area code ___ - ___ - ____

Authorized Person LAST Name

FIRST Name

Agency's Street Nmbr

Street Name

City

State

Zip

Authorized Party's e-mail:

The subject individual, whose identification I have confirmed, will provide direct care or supervision to individuals receiving care and/or services and is a subject individual concerning whom a criminal history record check is required by law (Article 28-E of the Public Health Law and Section 845-B of the Executive Law). I understand that the results of the criminal history record check will be used solely for purposes authorized by law and I will abide by the confidentiality requirements set forth in law. Informed consent (DOH CHRC Form 102) has been given by the subject individual and is on file.

Signature of Agency Authorized Person:

Date: ___ / ___ / ___ (MM / DD / YY)

SECTION 4 - FINGERPRINTING METHOD/IDENTIFICATION

Fingerprint Method:
○ Ink & Roll
○ Live Scan

Name & Address of Location where fingerprint services were performed

City

State

Zip

Identification verified before fingerprinting: (refer to Instruction #4)
○ Yes
○ No

The subject individual, whose identification I have confirmed, appeared before me for fingerprinting. I secured his/her fingerprints via the method indicated.

Signature:

First Name:

Last Name:

Title:

Date Fingerprinted ___ / ___ / ____ (MM / DD / YYYY)

*The Authorized Person shall inform the subject individual that disclosure of the Social Security Number (SSN) is voluntary and not mandatory and that it will be used to assist DOH-CHRC Unit in performing criminal history record checks.

BETHESDA
ELITE CARE

3 SURREY LANE MANORVILLE, NY 11949
781 SUFFOLK AVENUE BRENTWOOD, NY 11717
PHONE: (631) 503-7209
FAX: (632) 909-2445

EMERGENCY CONTACT INFORMATION

In case of an emergency, please contact the following person(s):

Employee Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Contact Person 1

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Relationship: _____

Contact Person 2

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Relationship: _____

JOB TITLE: Home Health Aide

REPORTS TO: Filed Staff Coordinator Supervisor and Director of Clinical Services

SUMMARY: A person who carries out health care tasks under the supervision of a Registered Nurse and who may also provide assistance with personal hygiene, housekeeping, and other related supportive tasks to a client with health care needs in his/her home.

JOB DUTIES:

1. Personal Care – assists with:
    a. Bath (bed, bath, tub, shower)
    b. Oral hygiene (mouth, denture care)
    c. Care of Hair (shampoo, dry and comb)
    d. Care of nails
    e. Skin care/lotion massage
    f. Position change
    g. Provide for elimination (bedpan, commode, toilet)
    h. Assist with dressing
    i. Take temperature and pulse

2. Treatments – assists with:
    a. Transfer and Ambulation
    b. Test urine
    c. Non-sterile dressings
    d. Use of prosthesis
    e. Active exercises
    f. Use of special equipment
    g. Take vital signs as ordered
    h. Intake and output
    i. Alcohol sponge
    j. Assist self-medicating clients with medication

3. Homemaking – assists with:
    a. Meal planning and preparation (prepare, serve, feed)
    b. Assist with feeding
    c. Linen change
    d. Laundry
    e. Light housekeeping (making beds, dust and vacuum, tidy kitchen and bathroom, wash dishes after meals)
    f. Grocery shopping, opening mail, banking and errands

4. The following functions are generally performed only after demonstration by the coordinating nurse:
    a. Tub, bath, or shower
    b. Care of catheter drainage bag
    c. Reinforce dressings and change simple, non-sterile dressings
    d. Ace bandage/elastic stockings
    e. Ice bag
    f. Simple soaks

g. Range of motion or prescribed services
h. Change of Ostomy equipment
i. Use of rehabilitative devices such as walker, wheel-chair, crutches, cane
j. Special skin care
k. Application of binders and other supports
l. Oxygen equipment
m. Relearning of household skills
n. Measure intake and output
o. Prepare modified diets
p. Collect stool and urine specimens
q. Prepare formula
r. Breast care for nursing mother
s. Perform alcohol sponge baths

5. An aide is NOT allowed to perform the following functions except as indicated in the Matrix entitled Permissible and Non-Permissible Activities: Home Health Aide (HHA) Services published by the New York State Department of Health on 8/19/1992.
    a. Enema
    b. Colostomy or catheter irrigation
    c. Tracheostomy care
    d. Gastric lavage or gavage
    e. Administer medications
    f. Change sterile dressings
    g. Tube feedings
    h. Give any medication – oral or injection
    i. Apply any form of heat
    j. Vaginal irrigation (douche)
    k. Decubiti care
    l. Make medical and/or nursing judgements
    m. Ant care not included in the nursing care plan

6. Documents care daily on all cases, reports to coordinating nurse any incidents or changes in condition of client.
7. Participates in Quality Improvement activities as indicated.
8. Attends staff meetings and in-service presentations, as required.
9. Attends case conferences as indicate.
10. Communicates effectively with all those providing care.
11. Immediately notifies agency of any unforeseen circumstances or changes in the client's condition.
12. Maintains client safety and confidentiality.
13. Observes and practices Standard and Universal Precautions.
14. Follows agency policy and procedure and provides care within the Home Health Aide Scope of Practice in a legal and ethical manner

QUALIFICATIONS

- Has successfully completed a basic home health aide training program approved by the New York State Department of Health and poses written evidence of such completion, or

- Hass successfully passed an equivalent exam approved by the New York State Department of Health and possesses written evidence of such completion.
- Has not been disqualified from employment resulting from a Criminal History Record Check submitted to the New York State Department of Health.

PHYSICAL REQUIREMENTS

The health status of all new personnel is assessed prior to assuming direct client care responsibilities. The assessment will include:

- A statement reflecting that the person is free from health impairment which is of potential risk to a client or which might interfere with the quality of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substance which might alter the individual's behavior;
- Documentation of immunization against rubella.
- Documentation of immunization against measles for all personnel born on of after January 1, 1957.
- Baseline TB screening using a two-step tuberculin skin test (TST) – i.e., Mantoux method or an approved whole blood assay for individuals with no PPD result sin the past year and a history of negative PPD. Documentation of negative chest x-ray and appropriate follow up, if applicable.
- Annual health assessment and TB screening (PPD or TBQ and appropriate follow up as needed) thereafter.

WORK ENVIRONMENT

- Works in the home environment with regular exposure to client elements and occasional stress.

COGNITIVE REQUIREMENTS

- Provides direct care according to the established client plan of care.
- Must work cooperatively with others and perform a wide variety of complex and complete tasks.

FUNCTIONAL ABILITIES

- Must be able to read twelve point or larger type and have normal color perception.
- Must be able to walk up and down stairs, lift, stoop, push, bend, reach, stand, sit, twist, and lift repeatedly throughout the day effectively so as to be able to perform the above listed functions.
- Must be able to hear adequately with no more than one amplifier on the phone and speak in a manner understood by most persons;
- Must be able to look at a computer monitor up to 2 hours daily
- Must have an acute sense of smell for normal perception

_____ _____

Signature of Home Health Aide **Date**

_____ _____

Signature of Field Staff Coordinator Supervisor **Date**

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

► **Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850.***

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the past 6 months; **or**
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ► **Date**

Please fill in these forms slowly and legibly.
(no script) *Rev. 2/25/16*

Company Name: Bethesda Elite Care
Company Code for Online Users: _____

Have you **worked for this Employer before?** **Are you a Re-hire?** **Yes**_____ **No**_____
If Yes, enter last day of employment: _____

Are you under age 40? **Yes**_____ **No**_____

Have you been **unemployed for at least 27 weeks,** and collected Unemployment Insurance? **Yes**_____ **No**_____

Are you a Veteran of the US Armed Forces? **Yes**_____ **No**_____
If *yes*:
Are you a member of a family that received SNAP (Food Stamps Benefits)? Yes_____ No_____
Are you entitled to compensation for a service-connected disability? Yes_____ No_____
Were you discharged from active duty within the last year? Yes_____ No_____
Were you unemployed for a combined total of 6 months before you were hired? Yes_____ No_____

Have you, or your family, received **SNAP benefits (Food Stamps)** in the **6 months** before you were hired? **Yes**_____ **No**_____
Or received **SNAP Benefits** for at least a **3 month period**, but you are no longer receiving it? **Yes**_____ **No**_____
If yes to either question, enter Name of Primary Recipient: _____
And City, State where benefits were received_____.

Are you a member of a family that received **TANF** assistance for at least 18 months before you were hired? **Yes**_____ **No**_____
Or, did your family stop being eligible for **TANF** assistance within 2 years before being hired, because you reached the maximum time those benefits can be received? **Yes**_____ **No**_____
If yes to either question, enter Name of Primary Recipient: _____
And City, State where benefits were received_____.

Did you receive Supplemental Security Income **(SSI Benefits)** for any month, ending within the 60 days, before you were hired? **Yes**_____ **No**_____

Were you convicted of a **Felony** during the year before you were hired? **Yes**_____ **No**_____

Were you referred to an employer by:
- A Vocational Rehab Agency approved by the state? **Yes**_____ **No**_____
- An Employment Network under the Ticket to Work Program? **Yes**_____ **No**_____
- The Dept. of Veteran Affairs? **Yes**_____ **No**_____

Print Name:	Social Security #:	Date of Birth:
_____	_____-_____-_____	_____

This company participates in various federal and state tax credit programs. This information in no way will negatively impact any hiring, retention decision. Your responses to the questions will only be shared with your employer's management and federal, state, or local governmental agencies as needed in administration of these programs. By completing this form, you knowingly and voluntarily waive any objection to providing your social security number. Any information provided will be used in a manner consistent with the American Disability Act. Under penalty of perjury, I certify that this information is true and correct to the best of my knowledge. I hereby authorize this company's management, and federal, state, and local government agencies to provide information to TC Services USA, Inc., and/or SWA, to determine eligibility. I understand that the information above may be subject to verification.

Employment Start Date_____ **Starting Wage**_____ **Position**_____

Signature_____ **Today's Date**_____

TC Services USA, Inc.
Phone: 212-994-2714 Fax: 212-994-2718 Email: support@tcservicesusa.com

New York State Department of Health
Division of Home and Community Based Services

RRDC:_____

EMPLOYEE VERIFICATION OF QUALIFICATIONS

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Employee to provide the Waiver Service

HSCC_____

Waiver Service you are applying for.

__HSCC_____
Waiver Service Position, if applicable

_**Bethesda Elite, Care Inc**
Service Provider Name

3 surrey Lane Manorville NY 11949
Address

(631) 400-9020
Telephone

I have submitted my resume and supporting documents which accurately reflects my education and work experience.

Employee Signature

Date

This individual has met the eligibility criteria for this position in the following manner:

Education: A copy of this individual's ___✓___ diploma or official sealed transcript
___✓___ license is attached to this form.

Experience: ___✓___ This individual's experience, relevant to this position, is highlighted on his/her attached resume. ***(**Please circle this person's relevant experience on the attached resume for quick reference for the interviewers).***

I have interviewed this individual and reviewed his/her resume. I verified his/her education, required licensures and work experience. Per waiver eligibility criteria, this individual is qualified to provide waiver services in the above named position and has been hired as an employee of our agency.

Service Provider Representative | Title | Signature | Date

New York State Department of Health
Division of Home and Community Based Services

RRDC:_____

EMPLOYEE VERIFICATION OF QUALIFICATIONS

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Traumatic Brain Injury (TBI)

Employee to provide the Waiver Service

HCBS Waiver Service you are applying for

HCBS Aide

Waiver Service Position, if applicable

_Bethesda Elite Care, Inc
Service Provider Name

3 surrey Lane Manorville NY 11949
Address

(_631 -400-9020 /(631) 503 -7209
Telephone

I have submitted my resume and supporting documents which accurately reflects my education and work experience.

Employee Signature

Date

This individual has met the eligibility criteria for this position in the following manner:

Education: A copy of this individual's ✓ diploma or official sealed transcript
✓ license is attached to this form.

Experience: ✓ This individual's experience, relevant to this position, is highlighted on his/her attached resume. ***(**Please circle this person's relevant experience on the attached resume for quick reference for the interviewers)***.

I have interviewed this individual and reviewed his/her resume. I verified his/her education, required licensures and work experience. Per waiver eligibility criteria, this individual is qualified to provide waiver services in the above named position and has been hired as an employee of our agency.

Service Provider Representative | Title | Signature | Date

TBI A 1.4 Rev. July 2009

781 SUFFOLK AVENUE BRENTWOOD NY 11717 PH (631)503-7209 FX (631) 909-2445

HISTORY & PHYSICAL

NAME: _____

ADDRESS: _____

PHONE #: _____ LAST 4 OF S.S. #_____

DATE OF BIRTH: ___/___/___ DATE OF EXAM: ___/___/___

VITAL SIGNS: HEIGHT: _____ WEIGHT: _____ BP: _____ TEMP: _____ RESP.: _____

SEROLOGY

ANTIBODY	TITER	IMM	NONIMM	DATE
RUBELLA				
RUBEOLA				
MUMPS				
HBs AB				
VARICELLA				

IMMUNIZATIONS

VACCINE	N/A	GIVEN	DATE
TD			
MMR			
HEPATITIS B			
VARICELLA			
INFLUENZA			

1ST PPD/MANTOUX DATE IMPLANTED: _____ DATE READ: _____
INDURATION: _____ LOT #: _____ MANUFACTURER: _____
EXP: _____ ☐ Positive ☐ Negative

2ND PPD/ MANTOUX DATE IMPLANTED: _____ DATE READ: _____
INDURATION: _____ LOT #: _____ MANUFACTURER: _____
EXP: _____ ☐ Positive ☐ Negative

3rd Annual Blood Test QuantiFERON TB GOLD (alternative to TST)
Blood test IFN concentration _____ IU/ML Test Date ___/___/___ ☐ positive ☐ negative ☐ Intermediate
CHEST X-RAY (IF PPD IS POSITIVE):
DATE: ___/___/___ RESULT: _____ PLEASE ATTACH CHEST X-RAY REPORT.

DRUG SCREEN DATE: ___/___/_____ PLEASE ATTACH LAB REPORT.

DIPHTHERIA DATE GIVEN: ___/___/___ BOSTER REQUIRED EVERY 10 YEARS.

TETANUS DATE GIVEN: ___/___/_____ BOSTER REQUIRED EVERY 10 YEARS.

FITNESS TO WORK

BASED ON THE HEALTH HISTORY, PHYSICAL EXAM, AND LAB TEST PERFORMED, THIS PERSON IS:

- FIT TO WORK WITHOUT LIMITATIONS OR RESTRICTIONS
- FIT TO WORK WITH RESTRICTIONS OR LIMITATIONS

DR. SIGNATURE AND STAMP: _____ **DATE:** ___/___/___

Updated: 11/17/17