APPLICATION FOR EMPLOYMENT

Please read the following carefully before filling out this form:

We do not discriminate on the basis of race, color, religion, national origin, sex, age, or disability. It is our intention that all qualified applicants be given equal opportunity and that selection decisions be based on job-related factors.

I certify that all information provided in this employment application is true and complete. I understand that any false information or omission may disqualify me from further consideration for employment and may result in my dismissal if discovered at a later date.

I authorize the investigation of any or all statements contained in this application. I also authorize, whether listed or not, any person, school, current employer, past employer and organization to provide relevant information and opinions that may be useful in making a hiring decision. I release such persons and organizations from any legal liability in making such statements.

I understand that if I am extended an offer of employment, it may be conditioned upon my successfully passing a complete pre-employment physical examination, my submitting a current negative tuberculosis test and my completion of any pre-employment mandatory training. I consent to the release of any or all medical information as may be deemed necessary to judge my capability to do the work for which I am applying.

I also understand that I will be subject to a criminal background investigation, adult abuse registry check, National Sex Offender Registry, Office of Inspector General, and child abuse registry check prior to employment.

I UNDERSTAND THAT THIS APPLICATION OR SUBSEQUENT EMPLOYMENT DOES NOT CREATE A CONTRACT OF EMPLOYMENT NOR GUARANTEE EMPLOYMENT FOR ANY DEFINITE PERIOD OF TIME. IF EMPLOYED, I UNDERSTAND THAT I HAVE BEEN HIRED AT THE WILL OF THE EMPLOYER AND MY EMPLOYMENT MAY BE TERMINATED AT ANY TIME, WITH OR WITHOUT CAUSE AND WITH OR WITHOUT NOTICE. I UNDERSTAND THAT IF A CLIENT IS REMOVED FROM SERVICE, OR REQUESTS AN ALTERNATE WORKER, THERE IS NOTHING THAT ALLIANCE HOME HEALTH CARE, INC. CAN DO TO ALTER THE SITUATION. THIS SITUATION DOES NOT CONSTITUTE A TERMINATION OR RELEASE OF EMPLOYMENT ON THE PART OF ALLIANCE HOME HEALTH CARE, INC. AND THEREFORE DOES NOT ENTITLE THE EMPLOYEE TO UNEMPLOYMENT COMPENSATION. IF AN EMPLOYEE LOSES HOURS FOR ANY REASON IT IS THEIR RESPONSIBILITY TO CONTACT THE OFFICE EXPRESSING THEIR DESIRE FOR ADDITIONAL WORK. FAILURE TO DO SO WILL BE INTERPRETED AS A VOLUNTARY TERMINATION OF EMPLOYMENT. BY SIGNING BELOW, I ACKNOWLEDGE THAT THERE IS NO GUARANTEE ON THE AVAILABILITY, REGULARITY, OR TIMELINESS OF EMPLOYMENT HOURS

I have read, understand, and by my signature consent to these statements. This application for employment will remain active for a limited time. Ask the organization representative for details.

SIGNATURE: _____

Shaded areas are for employer verification orders only

Personal Information (Please Print)

Name *Last*	*First*	*Middle (Full)*	
Other Names Used *(Include aliases, maiden & nick names)*			
Address			Apt #
City		State	Zip
Home Phone	Work Phone	Social Security #	E) SSN Verification ☐
Have you used any names or Social Security Numbers other than given above? If yes, list here:			D) Criminal Background Report ☐

Employment Desired

Position(s) Applied For		Date of Application
Are you currently employed? ☐ Yes ☐ No May we contact your present employer? ☐ Yes ☐ No		If "no," check here: ☐
Are you prevented from lawfully becoming employed in this country because of Visa or Immigration status? ☐ Yes ☐ No	If "yes," explain:	
On what date would you be available for work?		
Have you ever been convicted of any law violation? *(Include any plea of guilty or no contest. Exclude minor traffic violations.)* *Note: A conviction will not necessarily disqualify an applicant for employment..*		A) 7-Year Kansas ☐ Other States ☐
If yes, gives dates, court locations and sentence.		B) 7-Year Federal ☐ 2nd Federal ☐
Are you free for assignment anywhere in the world, as occasion demands? ☐ Yes ☐ No If "no," explain		

ALLIANCE
HOME HEALTH CARE. INC.

1831 Minnesota Ave., Kansas City, KS 66102
Phone: (913) 233-0160 Fax: (913) 233-0165

Qualifications for Hire

Employee is at least 18 years of age _____

Employee is able to read, write, and follow instructions _____

Please check all past experiences that apply

1. Has at least six months paid experience as:
   _____Agency Homemaker _____Nurse Aide _____Maid
2. Has at least one year experience (paid or unpaid):
   _____ Caring for Children _____Elderly _____ Infirm
3. Has successfully completed training as:
   _____Certified Nurse Aide _____LPN _____RN

Interview Notes

We sometimes offer shifts on short notice. Would this be a problem? ____ YES ____ NO

We must sometimes transfer heavy clients. Are you able to lift over 50 lbs.? ____ YES ____ NO

Please give an example of your dependability _____

_____

_____

Have you ever had to work with a difficult person? If so please explain how you handled working with this individual_____

_____

What is your 5 year goal plan?_____

_____

What is your availability?

_____

Please circle the following counties in which you are available to work:

Wyandotte Johnson Leavenworth Miami Douglas Franklin Linn Atchison Jefferson

FOR OFFICE USE ONLY: Admin Notes _____

_____

_____

Employment Experience

List names of employers in consecutive order with present or last employer listed first. Account for all periods of time including military service and any periods of unemployment. If self-employed, give firm name and supply business references. Note: A job offer may be contingent upon acceptable references from current and former employers.

Employer *(Current or last)*	Employed		Hourly Rate/Salary	
	From	To	Start	Final
Address				
City/State/Zip	Phone		C) Employment Verification ☐	
Job Title and Duties			Or "***NO*** ✎ for current	
Supervisor *Name*	*Department*			
Co-Worker *Name* *Department*	Co-Worker *Name* *Department*			
Reason for Leaving				

Employer *(Current or last)*	Employed		Hourly Rate/Salary	
	From	To	Start	Final
Address				
City/State/Zip	Phone		C) Employment Verification ☐	
Job Title and Duties				
Supervisor *Name*	*Department*			
Co-Worker *Name* *Department*	Co-Worker *Name* *Department*			
Reason for Leaving				

Employer *(Current or last)*	Employed		Hourly Rate/Salary	
	From	To	Start	Final
Address				
City/State/Zip	Phone		C) Employment Verification ☐	
Job Title and Duties				
Supervisor *Name*	*Department*			
Co-Worker *Name* *Department*	Co-Worker *Name* *Department*			
Reason for Leaving				

Education

	Name and Location of School *(Location should be name of City, State, Zip)*	Date		Graduate?	F) Education Verification
		From	To		
High School					☐
College or University					☐
College or University					☐
List Professional Licenses or Credentials					

References

List below the names of four persons not related to you whom you have known at least one year:

1.	Name Address	Phone	H) Personal References ☐
2.	Name Address	Phone	☐
3.	Name Address	Phone	☐
4.	Name Address	Phone	☐

EMERGENCY CONTACT

Name: _____

Relationship to the Applicant: _____

Phone Number: _____

Address: _____ City _____ State: _____ Zip: _____

Email Address: _____

ALLIANCE
HOME HEALTH CARE. INC.

1831 Minnesota Ave. Kansas City, KS 66102
Phone: (913) 233-0160 Fax: (913) 233-0165

EMPLOYMENT VERIFICATION FORM

PREVIOUS EMPLOYMENT:

Company Name: _____

Address: _____ City:_____ State: _____

Zip: _____ Phone: _____ Supervisor: _____

From: _____ To: _____

Reason for leaving: _____

By Signing this document below I, in order to obtain employment with Alliance Home Health Care, Inc., hereby authorize you to supply the information requested below. I waive any possible claim against you or your organization and agree to release you from any liability regarding the provision of such information.

Applicant Name:_____ Position Applied For: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: Home(_____)_____ Cell: (_____)_____

Applicant Signature: _____ Date: _____

WORK REFERENCE **Person Filling out form: _____**

Name while employed: _____ Position: _____

Employment Dates: From _____ To _____

Reason for leaving: _____

Would you rehire: Yes ( ) No ( )

Dependability: Above Average ( ) Average ( ) Below Average ( )

Attitude: Above Average ( ) Average ( ) Below Average ( )

Quality of Work: Above Average ( ) Average ( ) Below Average ( )

Please feel free to provide additional Comments: _____

_____

_____

For AHHC Office Use Only

Date Contacted _____ *Verified by* _____

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1831 Minnesota Ave. Kansas City, KS 66102
Phone: (913) 233-0160 Fax: (913) 233-0165

EMPLOYMENT VERIFICATION FORM

PREVIOUS EMPLOYMENT:

Company Name: _____

Address: _____ City:_____ State: _____

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Applicant Name:_____ Position Applied For: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: Home(_____)_____ Cell: (_____)_____

Applicant Signature: _____ Date: _____

WORK REFERENCE **Person Filling out form: _____**

Name while employed: _____ Position: _____

Employment Dates: From _____ To _____

Reason for leaving: _____

Would you rehire: Yes ( ) No ( )

Dependability: Above Average ( ) Average ( ) Below Average ( )

Attitude: Above Average ( ) Average ( ) Below Average ( )

Quality of Work: Above Average ( ) Average ( ) Below Average ( )

Please feel free to provide additional Comments: _____

_____

_____

For AHHC Office Use Only

Date Contacted _____ *Verified by* _____

HEALTH OCCUPATIONS CREDENTIALING
1000 SW JACKSON, SUITE 200, TOPEKA, KS 66612- 1365

CRIMINAL RECORD CHECK REQUEST FORM

FACILITY NAME: Alliance Home Health Care, Inc. **FACILITY ID #** A105045

ADDRESS: 1831 Minnesota Ave **CITY**: Kansas City **STATE:** Kansas

ZIP CODE: 66102

Applicant information: **ALL REQUESTED INFORMATION MUST BE PROVIDED** or the form will not be processed.

Last Name: First Name: Middle Name Suffix (Jr, Sr, etc)

Other Names Ever Used:

Last Name:

Last Name: **

** List additional names on back. Check here if more on back. ☐

Social Security Number Date of Birth Sex Race

One of the following **must** be selected
A - Asian or Pacific Islander
B - Black
I - Native American/Alaskan Native
W - White

Address Post Office Box # (if applicable)

City State County Zip Code

Home Phone Work Phone

Certificate # (if applicable)

Job Classification: Determine the correct job classification for the applicant and Insert the three letter abbreviation in the box.

Activities Staff	**ACS**	Food Service Worker	**FSW**	Medical Records Staff	**MRS**
Administrator	**ADM**	Home Health Aide	**HHA**	Operator	**OPR**
Business and Administrative	**BAS**	Home Health Aide Trainee	**HHT**	Paid Driver	**DRV**
Certified Medication Aide	**CMA**	Housekeeping	**HSK**	Paid Nutrition Assistant	**PNA**
Certified Nurse Aide	**CNA**	Human Resources Staff	**HRS**	Personnel Staff	**PER**
Nurse Aide Trainee	**NAT**	Laundry Workers	**LDW**	Restorative Ade	**RSA**
Chaplain	**CHN**	Maintenance Worker	**MTW**	Social Service Designee	**SSD**
Clerical Staff	**CLS**	Marketing Staff	**MKT**	Volunteer Coordinator	**VLC**
				Wellness Staff	**WEL**

FORM C - REV - 6/06

Completed by Date

Kansas
Department for Children and Families

Release of Information
Child and/or Adult Abuse and Neglect Central Registry Form

I give permission to check my personal information against the following registries:

☐ Child ($10 per person) ☐ Adult (Free) ☐ Both ($10 per person)

Confidentiality: Kansas Department for Children and Families' records are confidential. No individual, association, partnership, corporation or other entity shall willfully or knowingly disclose, permit or encourage disclosure of the contents of records or reports in violation of the confidentiality requirements of K.S.A. 38-2209. Violation of this statute is a Class A nonperson misdemeanor, and the court may impose a civil penalty of up to $1,000.

Return results by encrypted email to the following email addresses:

jcruz@alliancehomehealth.com ; mweaver@alliancehomehealth.com ; _____ ;

_____; _____

Payment/Account Information (Child Registry Only)

☐	**Online Payment**	Credit Card
☑	**Pre-Pay Account**	FEIN (XX-XXXXXXXX): 43--1974523
☐	**Mentoring Account**	Agency:
☐	**Exempt**	No fee for state government agencies (sub-contracting agencies not included).

I give permission for the release of any of my information in the Child and/or Adult Abuse/Neglect Central Registry to the contacts listed above. I understand the information released is for their exclusive and confidential use.

☐ Yes ☐ No

First Name: _____ Middle Name: _____ Last Name: _____

Other Names Used: _____, _____, _____

_____, _____

Date of Birth: _____ Race: _____ Social Security Number: _____

Gender: ☐ Male ☐ Female Address: _____

City:_____ State: _____ Zip Code: _____ Phone Number: _____

Email: _____

Signature: _____ Date: _____

***Signature must be ink or electronically verified by a reputable company.**

Applicant is under the age of 16 and I am (relationship to applicant): _____

Results will be sent electronically.

*This form is to remain on file for the duration of the active relationship between the agency and the person being searched.
DCF reserves the right to audit at any time to make sure all forms are up to date and on file.