MOSES HOMECARE *Independent Contractor Application*

Date Placed on Active Registry _____
(Office Use Only)

***Personal Information**: (Please Print Information)*

Professional Certification: ☐ *RN* ☐ *LPN* ☐ *CNA* ☐ *PCA* ☐ *Companion/Sitter*

Applicant's Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

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

Business/Home Phone: _____ *Cell Phone:* _____ *Other:* _____

Business/Home Address: _____

*Mailing Address (if different from Above Address):*_____

*Emergency Contact Phone #:*_____

Are you US citizen? ☐ *Yes* ☐ *No*
If "NO" do you have a current Work Authorization Card? ____ *Yes* ____ *No*

Education

Name and location of school		*Years Attended*	*Did you Graduate?*	*Subjects studied*
High school				
College/ Trade / business				

Professional History: *(Please list professional history for **the past 5 years** – **include the month and year** starting with the **latest one first**)*

Date Month and year	***Name & address of company***	***Salary***	***Position***	***Reason for leaving***
From				
To				
From				
To				
From				
To				
From				
To				

***References**: (please list **three business** references who are not related to you)*

Name	*Phone number*	*Personal or business*	*Years Known*

Background Information:

Have you ever been charged with a crime that was later dropped or dismissed? ☐ *Yes* ☐ *No*

If "Yes", what were the charges? _____

Where? _____Date: _____

Have you ever pled guilty to or been convicted of a crime that is a felony or first-degree misdemeanor? ☐ *Yes* ☐ *No*

If "Yes", what were the charges? _____

Where? _____ Date: _____

Have you ever had adjudication of guilt withheld to a crime that is a felony or a first-degree misdemeanor? ☐ *Yes* ☐ *No*

If "Yes", what charges? _____

Where? _____ *Date:* _____

Note: A "Yes" answer to these questions does not automatically bar you from an Independent Contractor opportunity. The nature, severity and date of the offense in relation to your registration will be considered.

It has never have been shown by credible evidence (e.g. a court or jury, a department investigation, or other reliable evidence) that I have abused, neglected, sexually assaulted, or deprived any person or to have subjected any person to serious injury as a result of intentional or grossly negligent misconduct as evidenced by an oral or written statement to this effect obtained at the time of registration.

_____*Contractor's Initials*

Certification / Consent of Release

I am aware that any omissions, falsifications, misstatements, or misrepresentations may disqualify me from consideration and may be grounds for not being called for referrals. I understand that any information I give may be investigated as allowed by law. I consent to the release of information contained in my registration file (which may include, but not limited to, licenses, certificates, medical information, Nation-wide criminal background check, references and documentation) when requested by a potential client or referral source. I consent to this release via telephone, facsimile, e-mails or mailing services. I certify that to the best of my knowledge and belief all of the statements contained herein and on any attachments are true, correct, complete, and made in good faith.

*Applicant Signature*_____ *Date*_____

Moses Home is looking for experienced and qualified care providers. Our qualifications include, but are not limited to:

- *Proof of Legal authorization to work in the United States*
- *High School Diploma or Equivalent*
- *Minimum of two years' experience as a care provider*
- *Passing a Caregiver Knowledge Assessment Test*
- *Clean National Criminal Background Screen*
- *Reliable transportation & proof of auto insurance*

If you are interested in pursuing an opportunity of joining our team of quality, compassionate, and dedicated care professionals providing caregiving services to individuals, then please complete the following information:

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____
Home #: _____ Cell #:_____

Best time to contact: _____

How did you hear about Moses Home: _____

Please give a brief description of your experience as a caregiver:

_____

_____

_____

Please state why you believe you are such a good caregiver & that Moses Home should represent you:

_____

_____

_____

I have the following qualifications *(check all that apply):*

_____*CPR*
_____*First Aid*
_____*TB Test Results (within last year)*
_____*Chest X-Ray*
_____*Driver's License*
_____*Proof of Auto Insurance*
_____*Social Security Card*
_____*Permanent Resident Card or*
_____*Resident Alien Card or*
_____*Work Authorization Card*

Companion _____
*Special Needs Provider*_____
*Babysitter*_____
CNA License # _____
Received what Year _____
LPN License # _____
Received what Year _____
RN License # _____
Received what Year _____
Additional Certification _____
_____

Please select your preference for availability *(check all that applies):*

Time Frame	***Mon***	***Tue***	***Wed***	***Thu***	***Fri***	***Sat***	***Sun***	***(area below for office use)***
Early Morning (6am – 9am)								
Late Morning (9am – 12pm)								
Early Afternoon (12pm – 3pm)								
Late Afternoon (3pm – 6pm)								
Early Evening (6pm – 9pm)								
Late Evening (9pm – 12am)								
Overnight (12am – 6am)								
1 – 2 hours								
4 – 8 hours								
8 – 12 hours								
Any hours								
Live-In								

I have experience with the following age groups *(check all that applies):*

_____ *Infant – Preemies*
_____ *Infant – Newborn up to 12 months*
_____ *Toddlers – 1 to 4 years old*
_____ *Youth – 5 to 11 years old*
_____ *Teen – 12 to 17 years old*
_____ *Adult – 18 to 64 years old*
_____ *Senior – 65+*

I have experience with the following diagnoses *(mark all that applies):*

Social, Emotional, Behavioral:

_____ *Autism Spectrum Disorder*
_____ *Sensory Integration Disorder*
_____*Other:*_____

Physical:

_____*Amputation*
_____ *Blindness/Visual Impairment*
_____*Cerebral Palsy*
_____ *Developmental Delays*
_____*Hearing Impairment*
_____ *Mobility Challenges*
_____ *Orthopedics*
_____ *Spinal Cord Injury*

Developmental:

_____ *Down's syndrome*
_____*Mental Illness*
_____*Speech Delay*
_____*Other:*_____

Medical:

_____*Alzheimer's*
_____*AIDS/HIV*
_____*Anemia*
_____ *Arthritis*
_____ *Asthma*
_____ *Cancer*
_____ *COPD*
_____ *Dementia*
_____ *Diabetes*
_____*Epilepsy*
____ *Allergies*
____*Hospice*
____*Hypertension*
____ *Incontinence Bowel/Bladder*
_____*Obesity*
_____*Paralysis*
Seizure Disorder _____
Stroke _____
Other: _____

I have experience with the following

Ambulation _____
Bathing/Grooming/Hygiene _____
Bed Baths _____
Behavioral Support _____
Blood Sugar Testing _____
Body Lifting _____
Congestive Heart Failure _____
Feeding _____
Feeding Pumps _____
Foley Catheter Care _____
G-Tubes & J-Tubes _____
Hoyer Lift _____
_____ *Infection Control Protocol*
_____ *Insulation Injections*
_____ *I.V. Administration*
_____*Oral Hygiene*
_____ *Ostomy*
_____ *Oxygen Concentrators*
_____ *Peri-Care*
_____ *Pacemakers*
_____ *Portable O2*
_____*Radical Pulse*
_____ *Repositioning*
_____ *Respiratory Care*
_____ *Seizure Attendance*
_____ *Sign Language*
_____ *Special Dietary Requirements*
_____*Transfers*
_____*Wound Care*
Other: _____

Additional Services I am willing to perform *(check all that applies):*

_____*Appointment Transportation*
_____*Animal Care*
_____ *Dishes*
_____*Errands/Shopping*
_____*Grocery Shopping*
_____ *Ironing*
_____ *Laundry*
_____ *Linens Changed*
_____ *Light Housekeeping*
_____ *Meal Preparation*

I have a dependable car at my disposal at all times:

The make/model is _____; the year is _____
It has 2 doors_____ it has 4 doors_____

I am willing to travel up to:

_____*10 miles*
_____ *15 miles*
_____ *20 miles*
25 miles_____
30 miles_____
Other: _____

The languages I speak are *(circle all that applies):*

_____*Chinese*
_____ *Creole*
_____ *English*
_____ *French*
_____*Italian*
_____ *Russian*
_____ *Spanish*
_____*Ukrainian*
Other: _____

Following are my related hobbies and interests:

_____
_____

Are you able to work in the home if there are?
Cats _____ *Dogs* _____
Are you able to work with a client who smokes?
Yes _____ *No* _____
Other allergies or fears we need to be aware of? _____
_____
Any limitations (lifting, transferring, meal preparation, vehicle accessibility, etc.)?

_____
_____
_____

Is there anything else you would like to tell us about yourself?

_____
_____
_____
_____

AUTHORITY FOR RELEASE OF INFORMATION

I _____, hereby authorize Moses Home to conduct a Criminal history record information check in connection with my work. I authorize release and forever discharge said agency and persons from any and all liability, which may be incurred as a result of furnishing such information. I give consent to Moses Home to perform periodic criminal history backgrounds checks for the duration of my contract with this company.

_____ _____
Last Name *First Name*

_____ _____
Middle Name *Maiden Name*

_____ _____
Social Security Number *Date of Birth*

_____
Address

_____ _____
State (You live in) *County*

_____ _____
Sex *Race*

_____
Driver's License #

_____ _____
Signature *Date*

CONSENT FOR DRUG SCREENING

I, _____, AM AWARE THAT AS AN INDEPENDENT CONTRACTOR IT MAY BE REQESTED THAT I VOLUNTARILY CONSENT TO A DRUG SCREENING AT MY OWN EXPENSE. I HEREBY GIVE MY CONSENT FOR THIS SCREENING.

SIGNATURE: _____ DATE: _____

Independent Contractor Code of Ethics

Moses Home, Inc. personnel must treat all clients in a courteous and respectful manner.

1. Moses Home, Inc. personnel may not use client's car for personal reasons.
2. Moses Home, Inc. personnel may not consume the client's food or beverages.
3. Moses Home, Inc. personnel should never use client's telephone for personal calls. Moses Home, Inc. personnel should always identify themselves if they are answering the phone for the client.
4. Moses Home, Inc. personnel should never discuss politics or religious beliefs, or personal problems with the client.
5. Moses Home, Inc. personnel should not accept gifts or financial gratuities from the client.
6. Moses Home, Inc. personnel should never lend money or other items to the client, borrow money or other items from the client, or sell any items to or for the client.
7. Moses Home, Inc. personnel may not purchase any items for a client without their written request and in accordance with the client's Plan of Care. Any purchases should be for medical necessities.
8. Moses Home, Inc. personnel should never bring personal visitors to the client's home – even if they have the client's permission.
9. Moses Home, Inc. personnel must never smoke in client's home
10. Moses Home, Inc. personnel must never report for duty under the influence of alcoholic beverages or illegal substances, nor should he/she consume alcohol or illegal substances while at work.
11. Moses Home, Inc. personnel never sleep in the client's home unless stated in the client's Plan of Care.
12. Moses Home, Inc. personnel must treat client's belongings and residence with respect. Moses Home, Inc. personnel are guests at the client's home.
13. Moses Home, Inc. personnel should never give their personal phone number to the clients.
14. Moses Home, Inc. personnel may not work for the client on their own time or accept any type of payment for their work, including caring for the client during client's hospitalization.
15. If the client is unable to be left alone, Moses Home, Inc. personnel may not leave the client even if the service time is over. If there is no one to replace the Moses Home, Inc. personnel, he/she should call the office and explain why he/she has to remain longer.
16. Moses Home, Inc. staff should not move heavy objects such as furniture or appliances.
17. Moses Home, Inc. personnel should only take instructions from Moses Home, Inc. supervisor(s) not the client.
18. Moses Home, Inc. personnel should always follow the client's Plan of Care and cannot modify client's Plan of Care. If changes are needed, Moses Home, Inc. personnel should contact the clinical supervisor to make the changes.

Signature: _____ Date _____

CNA/INDEPENDENT CONTRACTOR

COMPANION/ SITTER

Responsibilities:

- Basic meal preparation
- Provision of transportation services
- Housekeeping
- Home Safety
- social interaction, and leisure activities

Qualifications:

Must have proof of current TB screenings with negative results. Must be a Certified Nurse's Assistant. Must have proof of CPR and First Aid Certification. Must have a valid Driver's License and current car insurance. Must pass a background check. Ability to read, write, and follow instructions and completion of training or pass competency assessment, as appropriate, for understanding needs of populations served, handling emergencies in the home and infection control.

_____ _____

Signature Date

CNA/INDEPENDENT CONTRACTOR

PERSONAL CARE SERVICES

Responsibilities:

- Assistance with bathing, toileting, grooming, shaving, dental care, dressing, eating,
- Taking vital signs,
- Other medically related activities when assigned.
- Proper nutrition
- Home management
- Ambulation and transfer
- household tasks

Qualifications:

Must have proof of current TB screenings with negative results.

Must be a Certified Nurse's Assistant.

Must have proof of CPR and First Aid Certifications.

Must have a valid Driver's License and current car insurance.

Must pass a background check.

Must be able to follow verbal and written instructions, complete written reports, demonstrate understanding and practical competency in understanding the needs and characteristics of the elderly, handicapped, or convalescing individuals.

_____ _____

Signature Date

PLEASE FILL IN ALL * AREAS

Employment reference inquiry

To: _____ Date: _____

Company: _____ RE: _____

Fax Number: _____ SSN: _____

_____ has applied for a position as _____
Applicant Name

_____ with Moses Home . We would be most grateful if you would furnish us with your forthright opinion of your experience with the above-referenced individual. A signed authorization to release the requested information is below.

If preferred, you may contact me via telephone at (678) 948-5297 regarding this request. Please be advised that all information obtained will be held in confidence. Thank you for your cooperation.

_____

Human Resources Representative

APPLICANT – **DO NOT WRITE** ABOVE THIS LINE

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I, _____,hereby authorize the below employer to provide any requested information to Moses Home, Inc. and release them from all liabilities in responding to inquiries in connection with my application.

Applicant Signature _____DATE_____

*APPLICANT – **DO NOT WRITE** ABOVE THIS LINE*

Applicant employed with your company from _____ to _____

Position held: _____ Salary: _____

Reason for Separation: _____ Eligible for Rehire? Yes ____ No ___

Please indicate (E) for Excellent, (S) for Satisfactory or (M) for Marginal in the following categories:

Overall job performance	E	S	M	Ability to grasp new Ideas	E	S	M
Character/Integrity	E	S	M	Initiative/Leadership	E	S	M
Appearance	E	S	M	Job Knowledge	E	S	M
Dependability	E	S	M	Cooperation	E	S	M

Comments: _____

Signature & Title _____ *Date* _____

POST-OFFER MEDICAL QUESTIONNAIRE

(To be maintained on a separate file of confidential medical records)

If there is any question or statement on this form that you do not understand, ask for assistance from the person interviewing you.

Name _____ Social Security # _____

Date of Birth _____ Height _____ Weight _____

By completing this form, I am verifying that the above named company has already resented a conditional job offer to me.

The Georgia Subsequent Injury Trust Fund protects employers from excess liability for worker's compensation when an injury to a worker merges with a preexisting impairment to cause a greater liability than would have resulted from the subsequent injury alone. In order to qualify for this protection, we must have prior knowledge of any preexisting illnesses or other ailment/injury you may have sustained in the past that may contribute to a percentage of permanent impairment. The presence of one or more impairments does not automatically render you unfit as an employee. All decisions will be made on job-related criteria. Reasonable accommodations will be made if appropriate, provided it does not pose an undue hardship upon the company making the conditional job offer.

CIRCLE THE APPROPRIATE YES OR NO AND COMPLETE THE APPROPRIATE BLANKS

Have You Ever Had?

Yes	No	Asthma	Yes	No	Diabetes
Yes	No	Migraine Headaches	Yes	No	Color Blindness
Yes	No	A head injury	Yes	No	an amputated foot, leg, arm, or hand
Yes	No	A fear of heights	Yes	No	Loss of sight of one or both eyes
Yes	No	Heart trouble	Yes	No	Cerebral palsy
Yes	No	Fainting spells or dizziness	Yes	No	Multiple Sclerosis
Yes	No	Swelling of the legs or ankles	Yes	No	Parkinson's disease
Yes	No	Skin rashes or Eczema	Yes	No	Cardiovascular disorder
Yes	No	Joint pains or Arthritis	Yes	No	Tuberculosis
Yes	No	Epilepsy	Yes	No	Mental retardation
Yes	No	Cancer	Yes	No	Hemophilia
Yes	No	Varicose Veins	Yes	No	Chronic infection of bone
Yes	No	Sickle Cell Anemia	Yes	No	Muscular dystrophy
Yes	No	Tendonitis	Yes	No	Ruptured disc
Yes	No	Repetitive Motion Disorder	Yes	No	Nervous trouble or treatment
Yes	No	Kidney Problems	Yes	No	Depression
Yes	No	Knee problems	Yes	No	Hypoglycemia
Yes	No	Pulmonary Disease (lung)			
Yes	No	Hay fever			
Yes	No	Stiffness of major weight bearing joints			
Yes	No	Compressed air sequels (damage to lungs, ruptured ear drum, etc. due to explosion, air concussion)			
Yes	No	Immobility of major weight bearing joints (ankles, knees, hip)			
Yes	No	Do you have partial hearing loss			
Yes	No	Have you ever had an audiogram (hearing test)? If yes, results_____			
Yes	No	Do you need glass to read or for distance?			
Yes	No	Any serious wrist problems including Carpal Tunnel Syndrome?			
Yes	No	Any broken bones? Which bones? _____			
Yes	No	High blood pressure? If yes, you do take any medication to control high blood pressure Yes No			
Yes	No	Any serious injuries? Date_____ Nature of the injury _____			
Yes	No	A hernia or rupture? Date _____			
Yes	No	Any neck pain or problems? Date_____			
Yes	No	Injured back? Date_____			
Yes	No	Surgery Date_____ Type? _____			
Yes	No	Ever refused surgery? If yes, why? _____			

HAVE YOU EVER HAD?

Yes No An allergic reaction to any drugs? Which drugs?
_____

Yes No Partial loss of uncorrected vision of more than 75 percent bilaterally?
Yes No Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months?
Yes No Any permanent condition that constitutes 20 percent impairment of a foot, leg, hand, or arm, or of the body as a whole?
Yes No Do you or have you within the past year participated in recreational drug use?
Yes No Have you participated in a drug abuse treatment program?
Where? _____

Yes No Do you currently take any medications? If so, what? _____

Yes No Do you have any conditions or have you sustained any injury that would have an effect on you capacity to perform the duties of this position without reasonable accommodations?

HAVE YOU EVER BEEN TREATED FOR?

Yes No Back pain Yes No Neck pain
Yes No Hand pain Yes No Mental conditions

HAVE YOU EVER BEEN REFUSED EMPLOYMENT OR UNABLE TO HOLD A JOB BECAUSE OF?

Yes No Sensitivity to dust
Yes No Inability to assume certain positions
Yes No Inability to perform certain motions
Yes No Other medical reasons? Please Specify below.

Estimate the number of workdays you have lost in each of the past two years. List you family doctor first.

_____

Yes No Have you ever been hurt on the job or filed a worker's compensation claim in the past?

If yes, how many times? _____ What Years? _____ _____ _____ _____ _____

Please provide pertinent facts to every previous ailment or injury contributing to impairment, as well as all previous workers' compensation claims in the space provided:

_____
_____

"OUR WORKERS COMPENSATION INSURANCE CARRIER MAY CHECK FOR PREVIOUS CLAIMS BY NAME AND SOCIAL SECURITY NUMBER. IF YOU HAD A PREVIOUS CLAIM OR INJURY, AND FAIL TO MAKE US AWARE OF IT, YOU MAY BE LEGALLY DENIED BENEFITS IN THE EVENT OF A NEW INJURY BY OPERATION OF THE LANDMARK RYCROFT RULING. FOR YOUR OWN PROTECTION AND APPROPRIATE MEDICAL CARE, PLEASE MAKE US AWARE OF ANY PREVIOUS INJURIES."

_____ / _____ _____
Signature Print Name Date

_____ / _____ _____
MH Representative Print Name Date