

# APPLICATION FOR EMPLOYMENT

We are an equal opportunity employer, dedicated to a policy of non-discrimination in employment on any basis including age, sex, race, creed, national origin, religious persuasion, marital status, political belief or disability that does not prohibit performance of essential job functions.

## PERSONAL INFORMATION (Please print)

Today's Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Present Mailing address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Date of Residence \_\_\_\_\_

Previous Mailing address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Date of Residence \_\_\_\_\_

Telephone \_\_\_\_\_

Social Security Number # \_\_\_\_\_ Driver License \_\_\_\_\_

1. Is there any information we would need about your name or use of another name for us to be able to check your work record? Please specify:  
\_\_\_\_\_

2. How were you referred to At Your Home Familycare? \_\_\_\_\_

3. If hired, can you show proof of age?  Yes  No

4. Are you over eighteen (18) years of age?  Yes  No

5. Have you ever been convicted of a felony?  Yes  No

(Note: a conviction will not necessarily disqualify from the application.)

## EMPLOYMENT RECORD Include all employment for the last five years. List current / most recent employer first.

1. Company Name: \_\_\_\_\_ Position Held: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Manager/Supervisor: \_\_\_\_\_ Employed From: \_\_\_\_\_ to \_\_\_\_\_  
Wage/Salary: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_  
Briefly explain your duties: \_\_\_\_\_  
May we contact them?  Yes  No

2. Company Name: \_\_\_\_\_ Position Held: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Manager/Supervisor: \_\_\_\_\_ Employed From: \_\_\_\_\_ to \_\_\_\_\_  
Wage/Salary: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_  
Briefly explain your duties: \_\_\_\_\_  
May we contact them?  Yes  No

3. Company Name: \_\_\_\_\_ Position Held: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Manager/Supervisor: \_\_\_\_\_ Employed From: \_\_\_\_\_ to \_\_\_\_\_  
Wage/Salary: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_  
Briefly explain your duties: \_\_\_\_\_  
May we contact them?  Yes  No

Note: use separate sheet to list additional employers if necessary. We will contact all employers listed unless you specify otherwise.

**PERSONAL/CHARACTER REFERENCES** Please do not include relatives or former employers

1. Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address \_\_\_\_\_ Years Known \_\_\_\_\_  
 Occupation \_\_\_\_\_

2. Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address \_\_\_\_\_ Years Known \_\_\_\_\_  
 Occupation \_\_\_\_\_

**IN CASE OF ACCIDENT OR EMERGENCY CONTACT:**

Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_  
 Do not write below this line

**FOR INTERVIEWER:**

District: <input type="checkbox"/> 1 - South Bay	<input type="checkbox"/> 3 - La Jolla to Tierrasanta	<input type="checkbox"/> 5C - North County Coastal
<input type="checkbox"/> 2 - East County	<input type="checkbox"/> 4 - San Diego Metro	<input type="checkbox"/> 5I - North County Inland
<input type="checkbox"/> 6 - Riverside County: ( <small>Temecula, Hemet, Murrieta, Warner Springs</small> )	<input type="checkbox"/> 7 - Orange County: ( <small>San Clemente, Mission Viejo, San Juan Capistrano</small> )	<input type="checkbox"/> Other:

**TYPES OF SERVICE: For Interviewer**

<input type="checkbox"/> Home Care Aide I	<input type="checkbox"/> Home Care Aide III
<input type="checkbox"/> Companionship/Socialization	<input type="checkbox"/> Professional Personal Care (CNA/CHHA)
<input type="checkbox"/> Chore	<input type="checkbox"/> Professional Respite Care (CNA/CHHA)
<input type="checkbox"/> Escort	
<input type="checkbox"/> Errands	<input type="checkbox"/> Childcare
<input type="checkbox"/> Homemaking	<input type="checkbox"/> General Populations
<input type="checkbox"/> Laundry	<input type="checkbox"/> DD Respite Care
<input type="checkbox"/> Meal Preparation	<input type="checkbox"/> DD Fam Cost
<input type="checkbox"/> Respite Care	
<input type="checkbox"/> Shopping (Groceries/Necessities)	<input type="checkbox"/> Miscellaneous
	<input type="checkbox"/> Care Management
<input type="checkbox"/> Home Care Aide II	<input type="checkbox"/> Emergency Response
<input type="checkbox"/> Ambulation	<input type="checkbox"/> Money Management
<input type="checkbox"/> Assistive Devices	<input type="checkbox"/> Urgent Services IHSS
<input type="checkbox"/> Bathing	<input type="checkbox"/> 12 Hour Live-Out
<input type="checkbox"/> Catheters (Assistance only)	<input type="checkbox"/> 24 Hour Live-Out
<input type="checkbox"/> Dressing	<input type="checkbox"/> Transportation
<input type="checkbox"/> Enemas (Assistance only)	
<input type="checkbox"/> Grooming	
<input type="checkbox"/> Hair Care	Comments: _____
<input type="checkbox"/> Incontinence (assistance only)	_____
<input type="checkbox"/> Medications Reminder	_____
<input type="checkbox"/> Menstrual (Assistance only)	_____
<input type="checkbox"/> Oxygen (Assistance only)	_____
<input type="checkbox"/> Toileting (Assistance only)	_____
<input type="checkbox"/> Transferring	_____
<input type="checkbox"/> Turning/Positioning	_____

FOR INTERVIEWER

CLIENT POPULATION:

<input type="checkbox"/> Child (0 - 17) <input type="checkbox"/> Adult (18 - 64) <input type="checkbox"/> Disabled Adult <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Senior (65+) <input type="checkbox"/> Mentally Disabled Comments: _____ _____
--

LIFTING ABILITIES as indicated by applicant:

<input type="checkbox"/> No Lifting <input type="checkbox"/> Light (up to 10 lbs.) <input type="checkbox"/> Medium (10-20 lbs.) <input type="checkbox"/> Heavy (20+ lbs.)
--

EDUCATION:

Education	Taken
<input type="checkbox"/> AYHF CGC	_____
<input type="checkbox"/> Other CGC	_____
<input type="checkbox"/> AYHF Transp	_____
<input type="checkbox"/> AYHF Cont Ed	_____
<input type="checkbox"/> On Line LA Lev I	_____
<input type="checkbox"/> On Line LA Lev II	_____
<input type="checkbox"/> On Line LA Lev III	_____
<input type="checkbox"/> CNA Cont Ed	_____
<input type="checkbox"/> CHHA Cont Ed	_____

CERTIFICATIONS:

Certificate	Expires
<input type="checkbox"/> CHHA	_____
<input type="checkbox"/> CNA	_____
<input type="checkbox"/> LVN	_____
<input type="checkbox"/> RN	_____
<input type="checkbox"/> LCSW	_____
<input type="checkbox"/> AmerRedCr (X1)	_____
<input type="checkbox"/> CPR (X2)	_____
<input type="checkbox"/> SFA (X2)	_____
<input type="checkbox"/> RCFE Cert <b>OIR#</b> _____	_____

I understand that I must provide proof of current automobile insurance for any vehicle(s) I operate, and my insurance limits. Furthermore, I agree to only use public transportation or rides until I provide proof of automobile insurance. I further understand that driving without a driver's license will be grounds for immediate termination.

Applicant's Initials: \_\_\_\_\_