

DE-MONDEK HOME CARE PROVIDER SERVICES LLC

EMPLOYMENT APPLICATION

POSITION INFORMATION

Position Applying For: Application Date:

Desired Start Date: Expected Hourly Rate: \$

Employment Type: ☐ Full-Time ☐ Part-Time ☐ PRN (As Needed)

Preferred Shift: ☐ Days ☐ Evenings ☐ Nights ☐ Weekends

Preferred Service Area(s):

PERSONAL INFORMATION

Full Name:

Street Address:

City: State: ZIP Code:

Phone Number: Email Address:

Social Security Number: Date of Birth:

Driver's License / State ID Number: State: Expiration Date:

Are you legally authorized to work in the United States? ☐ Yes ☐ No

Will you now or in the future require employment sponsorship? ☐ Yes ☐ No

Do you have reliable transportation? ☐ Yes ☐ No

Do you have valid automobile insurance? ☐ Yes ☐ No ☐ N/A

PROFESSIONAL SUMMARY

Please provide a brief summary of your caregiving, healthcare, or related work experience.

EDUCATION

Highest Level Completed: ☐ High School ☐ GED ☐ College ☐ Trade School ☐ Other:

School Name: Degree / Certificate:

LICENSES & CERTIFICATIONS

List all current licenses, certifications, and training. Attach copies if requested.

License / Certification	License / Certificate Number	State	Expiration Date
Certified Nursing Assistant (CNA)			
Home Health Aide (HHA)			
Medication Aide			
CPR / First Aid			
Driver's License			
Other:			

Do you have a valid driver's license?

☐ Yes

☐ No

Do you have reliable transportation?

☐ Yes

☐ No

Are you legally authorized to work in the United States?

☐ Yes

☐ No

Have you ever been excluded from Medicare, Medicaid, or any state healthcare program?

☐ Yes

☐ No

If yes, explain:

EMPLOYMENT HISTORY

List your work history starting with your most recent employer. Include all relevant paid employment.

MOST RECENT EMPLOYER

Employer: Position:

Supervisor: Phone:

Employment From: To: Reason for Leaving:

Primary Job Duties:

May We Contact This Employer?

☐ Yes

☐ No

If No, Please Explain:

PREVIOUS EMPLOYER

Employer: Position:

Supervisor: Phone:

Employment From: To: Reason for Leaving:

Primary Job Duties:

PROFESSIONAL REFERENCES

List two professional references who are not related to you and who can speak to your work performance.

May We Contact Previous Employer?

☐ Yes

☐ No

If No, Please Explain:

Reference #1

Name:

Relationship:

Phone:

Email:

Reference #2

Name:

Relationship:

Phone:

Email:

BACKGROUND AND DISCLOSURE

1. Have you ever been convicted of a felony or misdemeanor (other than minor traffic violations)?

☐ Yes

☐ No

If yes, please explain:

2. Are you currently under investigation for any criminal offense?

☐ Yes

☐ No

If yes, please explain:

3. Have you ever been found substantiated for abuse, neglect, or exploitation of a child, elderly person, or vulnerable adult?

☐ Yes

☐ No

If yes, please explain:

4. Have you ever been terminated or asked to resign from a job for misconduct?

☐ Yes

☐ No

If yes, please explain:

I understand that any offer of employment is contingent upon the results of a background check, reference checks, and verification of the information provided on this application.

APPLICANT CERTIFICATION AND AUTHORIZATION

I certify that the information provided in this application is true, complete, and accurate to the best of my knowledge.

I understand that any false information, omission, or misrepresentation may result in disqualification from employment or termination if hired.

I authorize De-Mondek Home Care Provider Services LLC to verify any information provided, conduct a background check, and contact all references and previous employers.

Applicant Signature:

Date:

FOR OFFICE USE ONLY

Date Received:

Application Received By:

Position Applied For:

Interview Date:

Interviewed By:

Background Check:

☐ Yes

☐ No

Reference Check:

☐ Yes

☐ No

Date:

Eligible for Hire:

☐ Yes

☐ No

Hire Date:

Background Date:

Notes:

CLIENT ASSIGNMENT PREFERENCES

Maximum distance you are willing to travel to a client's home:

- ☐ Up to 10 miles ☐ Up to 20 miles ☐ Up to 30 miles ☐ Up to 40 miles ☐ 50+ miles

Are you willing to provide care for:

- | | | |
|---|---|--|
| ☐ Infants / Toddlers (0-3 years) | ☐ Individuals with Physical Disabilities | ☐ Individuals with Dementia or Alzheimer's Disease |
| ☐ Children (4-12 years) | ☐ Individuals with Intellectual & Developmental Disabilities (IDD) | ☐ Individuals Receiving Hospice / End-of-Life Support |
| ☐ Teenagers (13-17 years) | ☐ Individuals with Autism Spectrum Disorder (ASD) | ☐ Individuals Who Use a Wheelchair or Have Limited Mobility |
| ☐ Adults (18-64 years) | ☐ Individuals with Down Syndrome | ☐ Bedbound Individuals |
| ☐ Seniors (65+ years) | ☐ Individuals with Mental Health Conditions | ☐ Clients Requiring Two-Person Assistance |

Are you willing to work in a home where there are:

- ☐ Dogs ☐ Cats ☐ Birds ☐ Reptiles
- ☐ Other Pets: ☐ Someone Who Smokes ☐ No Preference

Are you comfortable providing care for clients who:

- | | | |
|---|---|---|
| ☐ Use Oxygen | ☐ Require Mechanical Lift (Hoyer Lift) | ☐ Have Diabetes |
| ☐ Client Has a G-Tube
(Caregiver Comfortable Working Around It) | ☐ Require Gait Belt Assistance | ☐ Are Terminally Ill |
| ☐ Require Incontinence Care | ☐ Have Seizure Disorder | ☐ Need Assistance with Activities of Daily Living (ADLs) |
| ☐ Require Frequent Transfers | ☐ Need Range of Motion Exercises | ☐ Need Assistance with Instrumental Activities of Daily Living (IADLs) |
| ☐ Have Fall Risks | | |

Languages Spoken:

Are you bilingual?

- ☐ Yes ☐ No

If yes, language(s):

Which client assignments would you prefer NOT to accept? (Please explain)

AVAILABILITY

What days are you available to work? (Check all that apply)

- ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

What hours are you available to work?

From: AM / PM

To: AM / PM

Do you have any scheduling restrictions?

- ☐ Yes ☐ No

If yes, please explain:

ADDITIONAL INFORMATION

Is there any other information you would like us to know that may help us in considering your application?

REFERENCES

Please list three (3) professional or personal references who are not related to you.

1.	Full Name:		Relationship:	
	Phone Number:		Email:	
	Address:			
	City:		State:	Zip:
	How long have you known this person?			
2.	Full Name:		Relationship:	
	Phone Number:		Email:	
	Address:			
	City:		State:	Zip:
	How long have you known this person?			
3.	Full Name:		Relationship:	
	Phone Number:		Email:	
	Address:			
	City:		State:	Zip:
	How long have you known this person?			

DRIVING INFORMATION

Do you have a valid driver's license?	☐ Yes ☐ No	Driver's License Number:	
State of Issuance:		Expiration Date:	Date of Birth:
Do you have reliable transportation?	☐ Yes ☐ No	Are you comfortable driving clients in your own vehicle?	☐ Yes ☐ No
Do you have auto insurance?	☐ Yes ☐ No	Insurance Company:	
Policy Number:		Policy Expiration Date:	
Have you ever had your driver's license suspended or revoked?	☐ Yes ☐ No		
If yes, please explain:			