APPLICATION FOR EMPLOYMENT

1399 West 34th Ave Suite 101
Anchorage, Alaska 99503
Phone: (907) 929-2828
Fax: (907) 929-5858
Toll free – (866) 516-2687

AssistedCare Services, LLC
A Consumer Directed Personal Care Agency
Your Home. Your Care. Your Way.

Pre-Employment Checklist

Welcome to AssistedCare Services, LLC. We thank you wholeheartedly for your interest in our agency. To complete the Hiring Process, the following documents need to be submitted with your employment application or at a time designated by AssistedCare Services' Management:

- ☐ Proof of automobile insurance. Per CDPCA regulations, each PCA must carry the following minimum limits of liability, if they use their personal automobile in the course of doing business for AssistedCare Services, LLC.
  - $300,000 Combined Single Limit Liability Bodily Injury & Property Damage

  Or
  - $100,000 Bodily Injury per Person/ $300,000 Bodily Injury per Accident / $50,000 Property Damage per Accident/Split Limit Liability
- ☐ Vehicle Insurance Obligation form
- ☐ Completed and Signed Employment application with 3 references listed (Two written references are required for those applying for or who also want Chore and Respite work)
- ☐ Criminal Background Check Form----- **Submit a check** payable to the Department of Health & Social Services for a criminal background check. The cost for the background check is $79.25. ($54.25 for state processing and for FBI processing, and @25.00 for Online Processing). Two sets of fingerprints (one set for local and another for federal check). Finger printing services are offered by several companies locally. We have included a form from CasTech for your convenience, but you may go to:
  - CasTech Fingerprinting Service 337-5002
    6901 E. Tudor Road
  - Hi-Tech Fingerprinting and ID Services 563-4659
    3901 Old Seward Highway Suite #9
  - Independent Fingerprint Consulting 338-6066
    5929 Camden Cir, Anchorage, AK
- ☐ Valid current CPR and First Aid certifications or proof of registration
- ☐ Proof of complete Tuberculosis test (TB) or recent chest X-Ray
- ☐ Current Division of Motor Vehicle (DMV) driving record
- ☐ W-4 Form
- ☐ Copy of High School Diploma or Copy of Equivalent
- ☐ References liability release form
- ☐ Copy of any relevant certifications from Alaska or other states (ie ...CNA, PCA, RN).
- ☐ PCA availability worksheet
- ☐ Driver's record check authorization form
- ☐ Completed I-9 form
- ☐ Copy of Drivers license and Social Security Card
- ☐ PCA Enrollment Process completed

NOTE: Incomplete forms or failure to submit requested documents may delay processing of your employment application.

Hiring Packet reviewed by AssistedCare Staff:

_____

Name Signature Date

AssistedCare Services, LLC
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APPLICANT NAME: _____

POSITION APPLYING FOR: _____

EMPLOYMENT APPLICATION *EQUAL OPPORTUNITY EMPLOYER

1399 West 34th Ave Suite 101 Anchorage. Ak 99503
Telephone# (907) 929-2828 Fax# (907) 929-5858 Toll Free# (866) 516-2687
E-Mail hr@AssistedCareAK.com

Print in ink or type.

1. Answer all questions completely. Be sure to **sign** and **date** your application.
2. **Complete all sections on the application**. Resumes will not be accepted in lieu of applications. Do not use "see resume" on any section of the application.
3. At the time of employment with AssistedCare Services, LLC, you must submit proof of U.S. citizenship or authorization to work in the United States.
4. False statements or omission of material facts will result in rejection of your application or removal from employment after hire.

Date of Application:

PLEASE PRINT OR TYPE

PERSONAL INFORMATION

Last Name	First Name	Middle	Date of Birth	Social Security Number
Address			Apt. # P.O. Box	Home Phone
City	State	Zip		Business Phone or Cell Phone Number

Are you legally eligible for employment in the USA? ☐ Yes ☐ No	Are you below the age of 18? ☐ Yes ☐ No:	Do you have a high school diploma or GED certificate? ☐ Yes ☐ No

ADDITIONAL INFORMATION

Do you possess a valid driver's license (if job required)? ☐ Yes ☐ No State: _____ Driver's License # _____

Can you lift more than 50 lbs. while standing? ☐ Yes ☐

Do you have any health conditions that would prevent you from performing the duties as described? ☐ Yes ☐ No (If yes, please describe)

_____

Have you ever been arrested or convicted of a criminal offense? ☐ Yes ☐ No (If so, what and when) _____

_____

(Affirmative answer will not automatically disqualify you from being considered as a candidate for employment.)

Are you currently certified in CPR? ☐ Yes ☐ No

Are you currently certified in First Aid? ☐ Yes ☐ No

Do you have experience as a Personal Care Assistance (PCA)? ☐ Yes ☐ No If yes, please describe your duties:

_____

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EDUCATION

School Name	City/State	Graduated?	Major	Degree
High School				
College/University				
Technical/Trade School				
Business School				
Other Training/ Professional Licensing				

WORK EXPERIENCE

Please List Your Last Three Jobs Beginning with the Most Recent

1. Name of Present or Most Recent Employer			Address
Starting Date	Leaving Date	Description of Duties	Phone #
Month/Year	Month/Year		Reason for Leaving:
2. Name of Employer			Address
Starting Date	Leaving Date	Description of Duties	Phone #
Month/Year	Month/Year		Reason for Leaving:
3. Name of Employer			Address
Starting Date	Leaving Date	Description of Duties	Phone #
Month/Year	Month/Year		Reason for Leaving:

REFERENCES

Please List **three** references **NOT** including relatives or previous employers.

Name and Address	Occupation	Phone

EMERGENCY CONTACT INFORMATION

Name	Address	Relationship	Telephone Number

I certify that the information provided is true and correct to the best of my knowledge.

PLEASE READ CAREFULLY BEFORE SIGNING

APPLICATION FORM WAIVER

In exchange for the consideration of my job application by AssistedCare Services, LLC, I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements, and the like as they may exist from time to time, or other Company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of AssistedCare Services, LLC, or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the Program Administrator of AssistedCare Services, LLC. Both the undersigned and AssistedCare Services, LLC may end the employment relationship at any time, without specified notice or reason. If employed, I understand that AssistedCare Services, LLC may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize the investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for immediate dismissal at any time without any previous notice. I understand that the information in this application may be released in an authorized legal investigation. For the purpose of this certification, a photocopy of my original signature shall have the same force and effect as my original signature. I hereby give AssistedCare Services, LLC permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release AssistedCare Services, LLC from any liability as a result of such contract.

I also understand that (1) AssistedCare Services, LLC has a zero tolerance for drugs and alcohol in the workplace. We may require the employee to undergo mandatory testing if an employee is suspected of being under the influence in the workplace; (2) consent to and compliance with such policy is a condition of my employment; and (3) continued employment is based on the successful passing of screening under such policy.

I understand that, in connection with the routine processing of my employment application, AssistedCare Services, LLC may request documents or information as to my previous employment, education history, character, general reputation, and similar background information. I hereby release all parties and persons connected with any request for information from all claims, liabilities, and damages for whatever reason arising out of furnishing such information or that could be related in any way to the disclosure of information on any assessment or opinion of my suitability for employment, which may be provided.

I further understand that my employment with AssistedCare Services, LLC shall be probationary for a period of ninety (90) days, and further that at any time during the probationary period or thereafter, my employment relation with AssistedCare Services, LLC is terminable at will for any reason by either party.

AssistedCare Services, LLC is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, creed, color, religion, sex, sexual orientation, national origin, age, disability or political affiliation. We assure you that your opportunity for employment with AssistedCare Services, LLC depends solely on your qualifications.

Thank you for completing this application form and for your interest in our Company.

Printed Name:

Signature: _____ Date: _____
Unsigned application will not be processed

APPLICANT INSTRUCTIONS AND NOTIFICATION

Thank you for your interest in employment with AssistedCare Services, LLC. As an applicant interested in our employment process, the following are provided as helpful tips to assist you in the application process.

Screening of applications is based solely on the information you submit. When completing an application be sure it is accurate, complete and includes all information regarding your education, training and experience. Omitting information or providing inaccurate or incomplete information may disqualify you from further consideration. Remember, your application is a reflection of you!

All Sections on the applications must be completely filled out; a resume is optional, and can be very helpful, but do not consider it a substitute or use "see resume" on any section of the application. **Remember to sign and date your application.**

CONDITIONS FOR EMPLOYMENT:
Please read the following statements carefully as they constitute conditions for employment.

1. The information that I have provided on this application is accurate and true to the best of my knowledge.
2. I understand that any misrepresentation or omission of a fact on my application, resume or during the interview or hiring process may result in the refusal of employment, or if employed, immediate termination from employment.
3. The persons, schools, current and prior employers (if approved by me in the Employment History section), and other organizations or employers named in this application are authorized by me to verify the information I have provided and to provide information that maybe requested to arrive are an employment decision. I am willing that a photocopy of this authorization be accepted with the same authority as the original. I hereby waive and release all persons, schools, current and prior employers and other organizations from any liability rising from the disclosure of any of the above information whether in writing or orally, and further waive and release AssistedCare Services, LLC from any liability arising from reliance on the aforementioned information or the use, publication, or retention of such information within the context of its applicant review procedures.
4. I will be able, if hired, to certify that I am authorized to work in the United States of America, and understand that in accordance with the Immigration Reform and Control Act that I will be required to provide timely documentation of identity and employment eligibility.
5. In the event that I am employed, I agree to conform to all company rules and regulations. I understand and agree that if I am employed, I shall be employed on an at-will basis. As an at-will employee, I understand and agree that either the company or I can terminate our employment relationship at any time for any reason, with or without advance notice and with or without cause. I understand and agree that, although over the course of my employment, other terms and conditions of my employment may change, the at-will term of my employment will not change. I understand that no one other than the Program Administrator of the company may enter into any agreement with me contrary to the foregoing and that any such contrary agreement must be in writing and signed by the Program Administrator.
6. I agree to protect confidential information, trade secrets, and proprietary information of the AssistedCare Services, LLC, and licensers, marketing partners or clients entrusted to AssistedCare Services, LLC, and I will not disclose to AssistedCare Services, LLC any confidential information of others if not entitled to do so.

Signature: _____ Date: _____
Unsigned application will not be processed

Employment Reference

Applicant Name: _____ **Social Security #:** _____

Employer's Name: _____

Supervisor's Name: _____ Telephone #: _____

Address: _____ Fax#: _____

City, State, Zip: _____

I authorize the following information to be released to AssistedCare Services, LLC. I further release and hold harmless both _____ and AssistedCare Services, LLC from any and all liability that may potentially result from the release and/or use of such information. I understand that any information released by my prior employer strictest confidence, that it will be viewed only by those involved in the hiring decision, and that neither I nor anyone else not so involved will have the right to see the information.

Signature: _____ Date: _____

(Applicant: please complete the section above and return it with the rest of your application)

Dear Employer:

The individual above has applied to work for AssistedCare Services, LLC and has submitted your name as a former employer for reference purposes. Due to the serious nature and the responsibility of working in the healthcare industry, it is extremely important for us to perform thorough reference checks. Therefore we would appreciate your cooperation in completing the following questions and returning the form to us as soon as possible. (Fax: 907-929-5858) Thank you in advance for you cooperation and assistance.

Position(s) Held: _____ Employed From: _____ To: _____

Eligible for rehire: Yes ☐ No ☐

	Exceeds	Meets	Below
Quality of Work			
Quantity of Work			
Attendance Habits			
Communicates Effectively			
Demonstrates Competent Skills			
Demonstrates courteous, cooperative, respectful behavior towards co-workers and patients			
Ability to handle stress			
Overall Nursing Skills			

Additional Comments:

_____

_____

Name: _____ Title: _____

Signature: _____ Date: _____

(Employer: Please Fax Reference Form to (907)-929-5858. Thank You)

CasTech
Fingerprinting Services
2217 East Tudor Road, Suite 12
Anchorage, AK 99507
907-337-5002

The following information is necessary to prepare your fingerprint card(s):

Date: _____

Name: _____
Last First Middle

Aliases: _____
What other names used, i.e. Maiden name, Nick Names, etc.

Residence: _____
Street Address or P.O. Box

_____
City State Zip Code

_____
Citizenship

Physical Description:

_____
Sex Race Height Weight Eye Color Hair Color

Place of Birth: _____

Social Security Number: _____

Alaska Driver's License or Alaska Identification Card Number: _____

Office Use Only:

Time: _____ _____# Prints Amount: _____

Reason: _____ Referral: _____ Day: _____

Referring Agency: AssistedCare Service, LLC Phone: (907) 929-2828 Fax: (907) 929-5858

Department of Health & Social Services
Background Check Unit

Disclosure of Personal History
&
Release of Information Authorization

Case Number (Eight Digit Number)

Applicants are required to disclose any known civil or criminal information regarding them which would be a barrier to association with the entity which is submitting your application for background check under AS 47.05. or 7 AAC 10.900 – 7 AAC 10.990. Please attach additional pages, if necessary, to complete the required information.

Have you ever been charged with, convicted of, found not guilty by reason of insanity for, or adjudicated as a delinquent for, a crime listed in 7 AAC 10.905?
No ☐ Yes ☐ If yes, please describe: _____

_____

Have you ever been found by a court or agency of this or another jurisdiction to have neglected, abused, or exploited a child or vulnerable adult under Children in Need of Aid (AS 47.10), Protection of Vulnerable Adults (AS 47.24), or Office of the Long Term Care Ombudsman (AS 47.62) or a substantially similar provision in another jurisdiction?
No ☐ Yes ☐ If yes, please describe: _____

_____

Have you been found by a court or agency of this or another jurisdiction to have committed medical assistance fraud under Medical Assistance Fraud (AS 47.05.210) or a substantially similar provision in another jurisdiction?
No ☐ Yes ☐ If yes, please describe: _____

_____

Have you appeared on the centralized registry established under Centralized Registry (AS 47.05.330) or a similar registry of this state or another jurisdiction?
No ☐ Yes ☐ If yes, please describe: _____

_____

Release of *information Authorization*

I certify that the contents of this form and information provided with it are true, accurate, and complete. I understand that a willful misrepresentation of the information provided is cause for immediate denial or later revocation of authorization under Criminal History; Criminal History Check; Compliance (AS 47.05.310).

I, the undersigned, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization will be held in confidence in accordance with DHSS guidelines.

I, the undersigned, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

This form must be signed; if the individual is 16-17 years of age, a parent signature must also be included.

Applicant Signature	Date	Parent Signature (if applicable)	Date
Applicant Printed Name	Applicant SSN	Parent Printed Name	

Form revised February 22, 2007

APPLICATION FOR BACKGROUND CHECK
CENTRALIZED PROCESSING

X New ☐ Renewal ☐ Other				ASV02030000001
				Provider Identification Number
AssistedCare Services, LLC	Dwayne or Olaide Wolfe	(907) 929-2828	(907) 929 5858	
Name of Agency/Facility	Point of Contact	Phone Number	Fax Number	
P.O. Box 221876	Anchorage	Ak	99522	admin@AssistedCareAK.com
Mailing Address	City	State	Zip Code	E-Mail Address
Personal Care Agency	Senior and Disabilities Services			
State Program	State Division			

Instructions: Complete a separate form for each individual sixteen (16) years of age or older of an entity who owns, or is an officer, director, partner, member, or principal of the business organization that owns an entity; operators, employees, contractors, unsupervised volunteers, residents other than those receiving services, individuals having regular contact with residents who receive services, unless the individual is a family member or visitor of an individual who receives services, under the provisions of AS 47.05.310, which are the responsibility of the Department of Health and Social Services. Social security number is required to conduct background check. Failure to provide the information will result in application not being processed.

Applicant's Last Name	Applicant's First Name	Initial	Aliases, Maiden Name, Previous Married Name(s)

Current Physical Residence Address	Apt/Unit/Spc #	City	State	Zip Code

Mailing Address (if different from above)	Apt/Unit/Spc #	City	State	Zip Code

Home Phone Number	Alternate Phone Number	SSN	Driver's License No & State

Date of Birth	Date Alaska Residency Began	☐ Male ☐ Female	Date Association with Facility Began

Position Status	Position Title

Please list your previous residence for the last ten (10) years. City, State, and Country (if outside the USA). Attach additional page(s) if necessary.

From (Year)	To (Year)	City	State	Country	From (Year)	To (Year)	City	State	Country
From (Year)	To (Year)	City	State	Country	From (Year)	To (Year)	City	State	Country
From (Year)	To (Year)	City	State	Country	From (Year)	To (Year)	City	State	Country
From (Year)	To (Year)	City	State	Country	From (Year)	To (Year)	City	State	Country
From (Year)	To (Year)	City	State	Country	From (Year)	To (Year)	City	State	Country
From (Year)	To (Year)	City	State	Country	From (Year)	To (Year)	City	State	Country

ASSISTEDCARE SERVICES, LLC
VECHICLE INSURANCE OBLIGATION FORM

Year	Make of Vehicle	Model	Color
Owner		Driver	
Registered Owner (s) of Vehicle (Print)		Driver of Vehicle (print) (if different from registered owner)	
Telephone Number(s)		Telephone Number(s)	
Address		Address	
Driver's License Number	License Expiration	Driver's License Number	License Expiration
Insurance Company		Policy Expiration Date	
Policy Number			
Registered Owner's Signature		Driver's Signature	

1. I understand being employed as a PCA with AssistedCare Services, LLC requires me to drive a vehicle and maintain vehicle liability insurance coverage.
2. As the registered owner, I certify that the above-described vehicle has a valid registration and is covered as is indicated by the **attached copy of a current Proof of Auto Insurance Card**.
3. I certify that the aforementioned insurance coverage includes no less than $50,000/$100,000 for liability coverage and no less than $25,000 for property damage.
4. I certify that the aforementioned liability insurance coverage is in force and agree to advise the agency, in writing, of any changes in the above information.
5. I certify that the above vehicle is mechanically safe.
6. As a driver of the vehicle described above, I agree to furnish transportation for consumer when necessary.
7. As a driver and/or owner, I certify that I have read this form and that all requirements are met.
8. As an owner of the vehicle described above, I certify that the driver of above-described vehicle:
    - is in good physical and mental health and is safe to drive.
    - has a good driving record and does not have excessive traffic violations per DMV point count.
9. As a driver, I also certify that I meet the requirements of item 8, above.
10. This certification will remain in effect while employed with AssistedCare Services, LLC.

NOTE: If you drive your personal automobile while on AssistedCare Services, LLC business and you are involved in an accident; by law your liability insurance policy is the primary insurance. This agency does not cover nor is it responsible for, comprehensive and collision coverage to your car.

I understand and agree that:

- AssistedCare Services, LLC is authorized to check my driving record with the Department of Motor Vehicles prior to hire and periodically thereafter.
- The Agency DOES NOT provide comprehensive or collision coverage for damage to my vehicle.
- The Agency DOES NOT provide medical payments or uninsured motorist coverage for injuries to the occupants of my vehicle.
- The auto owner's liability insurance is primary. The Agency DOES NOT provide liability coverage.

Date	Driver's signature
Date	Vehicle Owner's Signature

AssistedCare Services, LLC
PCA Availability Worksheet

Name_____ Date_____

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Earliest Available to Start							
Latest Available to End							
Overnight?							
24 hour shift?	o Yes o No	o Yes o No	o Yes o No	o Yes o No	o Yes o No	o Yes o No	o Yes o No
Comments:							

Number of hours Desired _____ per week

♥ Put down the earliest you are available to work EACH day…leave nothing blank
♥ Put down the latest you are available to work EACH day….leave nothing blank
♥ Put down if you are willing to work overnights….mark Yes or No.. leave nothing blank
♥ Put down if you are available to work a 24 hour shift…mark Yes or No…leave nothing blank
IF AVAILABILITY EVER CHANGES, COMPLETE A NEW AVAILABILTY FORM

***Things to keep in mind when filling out your availability form*:**

♥ The more availability you have, the more opportunity we have to give you the number of hours you requested.

♥ We help others 24 hrs/day, 7days/week…this is not a 9-5, M through F job ☺ .
We schedule around the needs of our clients and juggle many caregiver schedules to accommodate, if your schedule is flexible to add hours as needed, or you are willing to help a client on short notice, you are more likely to obtain the number of hours you desire.
♥ It is not guaranteed that you will be scheduled for the exact hours you requested as a clients needs may be different from your preferred availability but we will work very hard toward filling your hours.
♥ We are growing, and as we grow, we will have more client hours available!

How do I request time off or change my availability*? ** Please remember that you are responsible for finding coverage at least two weeks before submitting a leave request**

♥ We will be sending everyone a few time off request forms from time to time with your pay check stub. (3 to a sheet, cut one off and keep the others for future use)
♥ You can get both time off request and availability forms from the office during office hours (Monday – Friday 9am -5pm)
♥ Also, they will be available for download at www.AssistedCareAK.com in the near future.
♥ Please take the time to fill out the form(s) yourself and send or drop them by the office.

NOTE: It is important that you fill these forms out rather than call us to fill the form out for you.
The completed form is the only way we can guarantee the information will be entered into the computer. However, while we will do everything possible to grant your time off request, we cannot guarantee it. The earlier the request is submitted to the office the better the chance your request will be honored as it gives the office more time to cover the client's scheduled.

Name_____ Signature_____

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Applicants may turn in packet in person during office hours.
Monday - Friday 9am to 5pm