Application Date: ______________________________

Last Name: ______________________________

First Name: ______________________________

Middle Intial: ______________________________

Address: ______________________________

City: ______________________________

State: ______________________________

Zip: ______________________________

Phone: ______________________________

Cell Phone: ______________________________

E-mail: ______________________________

Social Security #: ______________________________

Date of Birth: ______________________________

DOH Authorized Person:

Name: ______________________________ Title: ______________________________

EMERGENCY CONTACT INFORMATION:
In the event of an emergency, who is/are the person(s) we should contact?
Primary Contact:
NAME: ____
Telephone #: ____
e-Mail #: ____
Relationship: ____

Alternate Contact:
NAME: ____
Telephone #: ____
e-Mail #: ____
Relationship: ____

EMPLOYMENT APPLICATION

Last Name: ____________________ First Name: _________________________Middle Initial:________

Address: ____

City: _________________________State: ____________________Zip:__________________________

Home Phone:__________________Cell Phone:________________Email: ________________________

How do you hear about Personal-Touch please check ONE:

☐ Friend ☐ Family Member ☐ Patient ☐ Newspaper ☐ Flyer ☐ Internet Search ☐ Indeed

☐ Community Center (Which one: _____________________) Other (please specify: ____________________

Please answer each of the following questions: (Place an √ in appropriate box)

	YES	NO
Have you ever worked for, or registered with Personal-Touch before?	☐	☐
Are you applying for training as a Home Health Aide?	☐	☐
Are you already Certified?	☐	☐
If yes, which Agency:	______________________________	
Are you currently working at another Agency?	☐	☐
When was the last time you worked as a Home Health Aide?	Date:	________________

Which of the following days are you available to work? (check all that apply):

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

Which of the following shifts are you available to work (check all that apply):

☐ Days ☐ Evenings ☐ Weekends Are you available to work as "Live in" (24 hours per day) ☐ Yes ☐ NO

In which Boroughs are you available to work? (check all that apply):

☐ Brooklyn ☐ Bronx ☐ Manhattan ☐ Queens ☐ Staten Island ☐ Westchester

☐ Nassau ☐ Suffolk

Which of the following languages do you speak? (check all that apply):

☐ English ☐ Spanish ☐Russian ☐Chinese ☐ Creole ☐ Italian ☐ Polish ☐ Other: ____________

I affirm that, to the best of my knowledge, the information provided on this application is true:

Signature: Date:
____

AUTHORIZATION FOR PERSONAL TELEPHONE REFERENCES

I authorize the release of personal information regarding my experience to Personal Touch Home Care (the "Company") or any designated officer, employee, agent or representative to confer with the above named references. I understand that the Company may ask my references questions about my educational background, work experience, achievements, performance, attendance, and reason for separation from former employment. I authorize my references to answer such questions.
I understand that any information provided by my references will be solely for the purpose of determining my acceptability for employment with the Company.
I release all of the above named references from any claim of liability or damages, including but not limited to, claims for defamation, interference with contract, and negligence – which may arise or result from any truthful reference information provided by reference pursuant to this authorization.

Candidates Signature: ____ Date: ________________

REFERENCES:

1. Name: ____
   Address: ____
   City: ________________________________ State: ____________
   Phone: ________________________________

2. Name: ____
   Address: ____
   City: ________________________________ State: ____________
   Phone: ________________________________

3. Name: ____
   Address: ____
   City: ________________________________ State: ____________
   Phone: ________________________________

DEMOGRAPHIC FORM

Last Name: ____________________ First Name: _________________________Middle Initial:___________

Social Security: _____/________/ _________ Date of Birth: _______________

Address: ____

City: _________________________State: ____________________Zip:__________________________

Home Phone:__________________Cell Phone:________________Email: ________________________

Sex:____________ Race :________________Height: ________ Weight: _________Eye Color: ____________

Hair Color:_________ Place of Birth / Country of Origin: ____

What date and time is most convenient for you to be scheduled for your fingerprint appointment:
Please check one:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

☐ Early Morning: 7 am to 10 am ☐ Mid Day: 11 am to 2 pm ☐ Late Day : 3 pm to 5pm

Training Start Date: ________________________________ Training End Date: _______________________

Instructors Name: _________________________________ Certified By: ____________________________

Methodology: Core Training / CNA Competency

► Please note that every attempt will be made to accommodate you, but appointments for fingerprinting are based on availability, so we cannot guarantee that you will be scheduled on the day and time you most prefer. The day and time you specified will be used to help us with the scheduling process.

► By signing this form, you are consenting to have training and health care employment history listed on the NYS Home Care Registry. The Home Care Registry is about home care workers who have successfully completed a NYS approved training program. Information contained in the registry may be entered and updated by Personal Touch employees, and Personal Touch does not guarantee the accuracy of the information into this registry and will not be held liable for any such errors.

I have read the above and understand that my scheduled appointment may differ from my preferred request and that my health care employment and training history will be entered in the NYS Home Care Registry.

Signature: ____ Date: _______________

REFERENCE FORM

____

____

____

The undersigned has applied for employment with our company and authorizes you to provide Information concern- ing past performance under the provisions of the Privacy Act of 197 4. All information Is kept confidential. Thank you for your cooperation.   Sincerely, Personal-Touch Home Care

Name: ________________________________ Social Security #: ________________

Employment Dates: ____________ to ____________ Position: ________________

Reason for leaving: ____

Would you rehire?

EVALUATION	Excellent	Good	Average	Poor
Attendance				
Quality of Work				
Job Knowledge				
Cooperation				
Dependability				
Appearance				
Stability				
Overall Rating				

Comments: ____

____

Signature: ________________ Title: ________________ Date: ________________

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize you to Issue any Information you may have regarding my services and character and do hereby unoon- dltlonally release your organization from all llablllty for any damage whatsoewr which might result from furnishing same.

Applicant's Signature: ____ Date: __________

REFERENCE FORM

____

____

____

The undersigned has applied for employment with our company and authorizes you to provide Information concern- ing past performance under the provisions of the Privacy Act of 197 4. All information Is kept confidential. Thank you for your cooperation. Sincerely, Personal-Touch Home Care

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Reason for leaving: ______________________________

Would you rehire?

EVALUATION	Excellent	Good	Average	Poor
Attendance				
Quality of Work				
Job Knowledge				
Cooperation				
Dependability				
Appearance				
Stability				
Overall Rating				

Comments: ______________________________

____

Signature: ______________ Title: ______________ Date: ______________

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize you to Issue any Information you may have regarding my services and character and do hereby unoon- dltlonally release your organization from all llablllty for any damage whatsoewr which might result from furnishing same.

Applicant's Signature: ____ Date: ___________

NEW YORK STATE DEPARTMENT OF HEALTH

Criminal History Record Check

Department of Health

DOH CHRC form 102: Acknowledgement and Consent for Fingerprinting and Disclosure of Criminal History Record Information

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

Last Name	First Name	Middle Initial	Maiden Name

Date of Birth (mm/dd/yyyy)	Alias/AKA	Mother's Maiden Name

Mailing Address (street)	City	State	ZIP Code

SECTION 2 – ATTESTATION

1.	I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2.	I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3.	I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary. In accordance with applicable laws, DOH will furnish appropriate summary information to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
4.	I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5.	I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for a non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below. NYS Division of Criminal Justice Services Criminal History Bureau Record Review Unit-5th Floor 4 Tower Place, Albany, NY 12203 (518) 485-7675 Federal Bureau of Investigation Criminal Justice Information Services (CJIS) Division 1000 Custer Hollow Road, Clarksburg, WV 26306 (304) 625-5590
6.	I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7.	I certify to the best of my knowledge and belief that I (check as appropriate): ◯ Have ◯ Have not been convicted of a crime in New York State or any other jurisdiction ◯ Do ◯ Do not have a final finding of patient or resident abuse If you checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
8.	My current mailing or home address is indicated in Section 1 of this form.
9.	I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own.

Applicant Signature: Date: __ __ / __ __ / __ __ __ __

Name and Signature of Parent or Legal Guardian: (if subject individual is under 18 years of age)   Date: __ __ / __ __ / __ __ __ __

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: Personal Touch Home Care

Operating License Number (PFI): 0021L001

Print Name of Authorized Person: Carlita Perez

Title: Supervisor

Signature of Authorized Person: Date: __ __ / __ __ / __ __ __ __

This form is to be retained by the agency. Do not forward to the DOH CHRC