HELPING HANDS

HOMEMAKING SERVICE FOR CHRONICALLY ILL, INC.

5 Centre Street
Hempstead, NY 11550
(516) 489-6810 * (718) 658-4447
FAX: (516) 481-4131

130 Main Street
Northport, NY 11768
(631) 261-0403
FAX: (631) 261-3083

[ ] **[ ]**

HHA [ ] PCA [ ] DATE: _____

NAME: _____
LAST FIRST MIDDLE

ADDRESS:_____
STREET CITY ZIP CODE

TELEPHONE: _____ EMERGENCY/CONTACT #: _____

OTHER NAMES USED: _____

SOC. SEC. #: XXX-XX-_____ BIRTHPLACE: _____

CAR: YES [ ] NO [ ] DRIVE: YES [ ] NO [ ]

SCHOOLING:_____ OTHER TRAINING: _____

CERTIFICATE ISSUED BY: _____ DATE ISSUED: _____

HOW DID YOU HEAR ABOUT OUR AGENCY?: _____

IF YOU HAVE WORKED WITH OTHER AGENCIES, PLEASE LIST NAME & ADDRESS:

(1) _____

(2) _____

WORK REFERENCES

(1) NAME:_____ TELEPHONE: _____

STREET: _____ CITY: _____

WORKED PERFORMED: _____ STARTED: _____ ENDED: _____

(2) NAME: _____ TELEPHONE: _____

STREET: _____ CITY:_____

WORKED PERFORMED: _____ STARTED: _____ ENDED: _____

(3) NAME: _____ TELEPHONE: _____

STREET: _____ CITY:_____

WORKED PERFORMED: _____ STARTED: _____ ENDED:_____

I GIVE MY PERMISSION TO HAVE MY REFERENCES CHECKED:

_____
SIGNATURE

DO NOT WRITE BELOW – FOR OFFICE ONLY

I A H C P HOURS AVAILABLE: _____ C D DNU: YES [ ] NO [ ]

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EXPERIENCE CHECKLIST

NAME: _____

Please place a check next to any experience you have had in the past.

Patient Types and Conditions/Equipment

_____Addictions
_____Alcoholism
_____Alzheimer's
_____Arthritis
_____Asthma
_____Blindness
_____Burns
_____Cancer
_____Cerebral Palsy
_____Colostomy
_____Coma
_____Confusion/Disorientation
_____Convulsive Disorders/Seizures
_____CPR
_____Deafness
_____Decubiti
_____Diabetic
_____Dialysis Patients
_____DNR Orders
_____Dressing/Wounds
_____Drugs/Medicine
_____Emphysema
_____Eye Problems
_____Foley Catheters
_____Fractures
_____Gastrostomy Tubes
_____Geriatrics
_____Heart Condition
_____Heimlich
_____HIV
_____Hoyer Lift
_____Incontinence
_____Infant/Child Care
_____Kosher Households
_____Mental Retardation
_____Multiple Sclerosis
_____Newborn
_____Nutrition/Diets
_____OB/GYN
_____Oxygen
_____Paraplegics/Quadriplegics
_____Parkinsons
_____Polio
_____Prosthesis
_____Psychiatric
_____ROM Exercises
_____Speech Defects
_____Stroke
_____Surgery/Post-Op
_____Tracheostomy
_____Ulcers
_____Vital Signs

ANY OTHER EXPERIENCE YOU WOULD LIKE TO MENTION:

_____
_____
_____
_____
_____
_____

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MEDICAL FORM

Name_____ Date of Birth: _____

Address:_____ Telephone: ( ) _____

I consent to this examination and release of information:

Signature:_____ Social Security #:_____

. . . . . .

Note to physician: in making your medical evaluation of the above patient, please be aware that he/she will be employed as a health care provider, which may involve homemaking and/or patient care. We are interested in this person's ability to function in this capacity.

. . . . . .

To be completed by physician only:

Does patient have any neurological disabilities, such as epilepsy, dizziness, paralysis, etc.?_____If yes, please indicate type and degree of disability._____

Is the patient free from habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior? Yes____No_____If not, please explain: _____

_____

…….. . . . . .

PHYSICAL EXAMINATION:		NORMAL	ABNORMAL	Comment, if Abnormal:
Height:_____	EYES:			
	EARS:			
Weight:_____	NOSE:			
Blood Pressure:_____	THROAT:			
	LUNGS:			
Pulse:_____	HEART:			
Respiration:_____	BACK:			

LABORATORY TESTS:_____

RUBELLA	Date of Titre/Titre #:	OR	Date of Vaccine:
MEASLES * *Documentation Required of Immunity if born on or after 1/1/57.	Date of Titre/Titre #: or Documented History of Childhood Disease	OR	Date of Vaccine:
TUBERCULOSIS	PPD or Mantoux Skin Test Date Read/Results:	OR	Chest X-ray: Date/Results:
DRUG SCREEN	Date	NEG	POSITIVE (see report)
FLU VACCINES	Date	Seasonal	

I certify that the above named person is free of any infectious diseases and in my opinion:

Has no restrictions _____ Has the following restrictions:_____

Physician's signature: _____ **Physician's stamp:**

Date of examination: _____

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APPLICANT'S PERSONAL RECORD STATEMENT

PLEASE PRINT ALL INFORMATION CLEARLY

Employee Name_____

Address _____

City/State/Zip _____

Social Security Number _____Job Title _____

Have you ever been convicted of, or are you presently being charged with or under indictment for a misdemeanor? ☐ YES ☐ NO

Have you ever been convicted of, or are you presently being charged with or under indictment for a felony?
☐ YES ☐ NO

Have you been designated an "Ineligible Person"?*
☐ YES ☐ NO

If the answer to either of the above questions is YES, submit full details below.

I affirm, under the penalty of perjury, that the above statements are true and correct. I am aware that a criminal background check may be performed.

Signature _____ Date _____

A CRIMINAL CONVICTION WILL NOT AUTOMATICALLY BAR YOU FROM EMPLOYMENT WITH OUR COMPANY. FAIR CONSIDERATION WILL BE GIVEN FOR YOUR FITNESS FOR EMPLOYMENT.

*AN INELIGIBLE PERSON MEANS AN INDIVIDUAL OR ENTITY WHO/WHICH HAS BEEN EXCLUDED, SUSPENDED, DEBARRED OR OTHERWISE DEEMED INELIGIBLE TO PARTICIPATE IN A FEDERALLY FUNDED HEALTHCARE PROGRAM AND HAS NOT BEEN REINSTATED AFTER A PERIOD OF EXCLUSION, SUSPENSION, DEBARMENT OR INELIGIBILTIY.

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DUTIES REFERNCE FORM

To: _____

_____

_____

Re: _____

SS# _____

The above applicant has suggested that we contact you in order to obtain a reference concerning his/her character and work performance.

We would appreciate it if you would answer the questions below. Your reply will be held in strict confidence. Thank you for your attention to this matter.

Yours truly,
Kathleen Bagnall
Director

I hereby authorize the following information to be released to Helping Hands Inc./HSCI

Signature: _____ Date: _____

Job Title:_____ Dates of Employment: _____

Please Indicate: Excellent, Good, Fair, Poor

Disposition _____
Appearance _____
Attendance _____

Interpersonal Relationships _____
Performance of Duties _____
Would you rehire? _____

Reasons for leaving employ:_____

DUTIES: (Please check all that apply)

Bathing Patient……..... _____
Assist with Care of Teeth and Mouth…… _____
Care of Clothing and Linen…… _____
Assist with Meal Planning and Prep…… _____
Assist Patient with Dressing…… _____
Use and Care of Special Equipment…… _____
Homemaking/Cooking…… _____

Skin Care..…….. _____
Assist with Grooming…….. _____
Assist Patient with Eating…….. _____
Assist with Moving or Walking.. _____
Assemble Supplies, Equipment. _____
Recordkeeping…… _____

Name of Person Replying (please print): _____ Relationship to Patient: _____

Telephone #: _____ Date: _____ Signature: _____

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JOB REFERNCE FORM

To: _____ Re: _____

_____ SS# _____

_____

The above applicant has suggested that we contact you in order to obtain a reference concerning his/her character and work performance.

We would appreciate it if you would answer the questions below. Your reply will be held in strict confidence. Thank you for your attention to this matter.

Yours truly,
Kathleen Bagnall
Director

I hereby authorize the following information to be released to Helping Hands Inc./HSCI

Signature: _____ Date_____

Job Title: _____ Dates of Employment: _____

Please Indicate: Excellent, Good, Fair, Poor

Disposition _____ Interpersonal Relationships _____
Appearance _____ Performance of Duties _____
Attendance _____ Would you rehire? _____

Reasons for leaving employ:_____

Please circle: Full-Time Part-Time Intermittent Steady

POSITION: Registered Nurse Home Health Aide

Licensed Practical Nurse Personal Care Aide Other

Description of duties: _____

_____

Name of Person Replying (please print): _____ Date: _____

Telephone #:_____ Signature: _____