Heritage Senior Care

Caregiver Application

Please fill out **EVERY** page, **LINE** or **YES** and **NO** question applicable in this application packet!

First Name: _____ **Last** Name: _____

Email: _____ **Today's** Date: _____

Are you legally eligible to work in this country? Yes ____ No ____ Are you over 18 years of age? Yes ____ No ____

Phone Number (Cell): _____

Cell Carrier: _____
(Such as AT&T, Cingular, T-Mobil, Verizon, etc…)

Do You Have Proof or Bring With You Copies of:
CNA licenses ___ or **CHHA** licenses ____
TB results ____ **CPR/1st Aid** card ___

Home Address: _____ Apt#: _____ City: _____ Zip Code: _____ Do you have a car: Yes____ No ____ Make _____ Model _____

Do you have a Driver's License: Yes____ No ____ Car insurance: Yes____ No ____

Emergency Contact Name: _____ **Phone Number**: _____

This job may require some lifting, bending and stretching. Are you able to perform the essential functions of the position for which you are applying either with or without reasonable accommodations? Yes ____ No ____

Do you have a **weight restriction** for lifting people? Yes ____ No ____ If **Yes**, give weight limit or range: _____

What Are Your SKILLS or EXPERIENCE: (*check a and fill-in all that applies*)

Alzheimer	____	Hospice	____	Can you speak a language other than English?	
Bed Patient Care	____	Hoyer Lift (can operate)	____	If yes, please list: _____	
Bed Bath	____	*Light Housekeeping	____	_____ _____	
Catheter (empty)	____	(*MOST shifts require some	____	Do you have allergies to pets? Yes ____ No ____	
Cancer	____	light housekeeping at least 20%)		if Yes: Dog ____ Cat ____ Bird ____	
CHF(**C**ongestive		Parkinson's	____		
Heart **F**ailure)	____	Shower (stand by assist)	____	►*Are you a US Veteran?* Yes ____ No ____	
Colostomy (empty)	____	Stomach Tube (peg-tube)	____	►*Are you accepting SNAP benefits?* Yes ____ No ____	
Companionship ONLY	____	Stroke	____	►*Are you currently or have you been trained through*	
Cooking (meal prep)	____	Transfer Board	____	*WOTC* Yes ____ No ____	
COPD (**C**hronic **O**bstructive		Transfer with Assistance	____	*ESE* Yes ____ No ____	
Pulmonary **D**isease)	____	Wheelchair Transfer	____	*EDD* Yes ____ No ____	
Dementia	____	Walker Assist	____	(This ► symbol indicates some financial incentives)	
Diabetes	____	Are you a smoker? Yes ____ No ____			
Diapers/Depends	____	Will you work with a client who smokes? Yes ____ No____			
Emphysema	____	Will you drive a client in **your** car? Yes ____ No ____			
Hip Replacement	____	in **their** car? Yes ____ No ____			

How did you hear about Heritage? _____ Such as: a Friend/Family member/Care Giver from Heritage, Heritage web page, Internet/Craigslist/Zip recruiter, Career Center, School/College, newspaper/magazine, Penny Saver, Job Fair, Senior Care Facility, Hospital, flyer, Social Worker, Yellow Pages, Walk-in, etc…

Availability- Please Check What shifts you are interested in:

Hours Preferred: 4 hrs __ 8 hrs ___ **Day's Preferred:** Sun __ Mon __ Tue __ Wed__ Thurs__ Fri __ Sat __

Times during day: Morning ___ Afternoon ___ Night ___ **Hours** Preferred: _____

Counties & **Cities** you are **willing to work in or travel too**: _____

_____

_____ Hourly **Pay Rate** Desired: _____

Are you, or have you ever been on **Workers Compensation**? If so; please give Date: _____

Explain Injury: _____

Beginning 1/1/16 The California Department of social Services, Home Care Services Bureau REQUIRES that you complete a registration process before we can hire you. This includes a fingerprint clearance, statement of prior convictions, TB Clearance and registration on the home Care Aide Registry. We assist you in that process, then once accepted by CDSS/HCSB, we then begin our process of hiring.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

COMMUNITY CARE LICENSING DIVISION HOME CARE SERVICES BUREAU

APPLICATION FOR HOME CARE AIDE REGISTRATION

Please type or print clearly. For instructions on how to complete this form refer to page two. Please ensure that you include a check or money order in the amount of $25.00 payable to the California Department of Social Services and complete LiveScan form (LIC 9163) and submit fingerprints. Mail this completed application, the complete Criminal Record Statement (LIC 508) and a check or money order to: The California Department of Social Services, Home Care Services Bureau 744 P Street, MS T8-3-90, Sacramento, CA 95814.

For Department Use Only	
LIC 508 FILED WITH APPLICATION? ☐ YES ☐ NO	
FEES INCLUDED? ☐ YES ☐ NO	AMOUNT

☑ **New Application** ☐ **Renewal Application**

1. NAME

LAST:	FIRST:	MIDDLE:

2. LIST ALL OTHER NAMES YOU HAVE EVER USED, SUCH AS MAIDEN OR ALIASES (AKAs)

3. RESIDENCE ADDRESS

STREET:	APT:	CITY:	STATE:	ZIP:	COUNTY:

4. MAILING ADDRESS (If Different):

P.O. BOX/STREET:	APT:	CITY:	STATE:	ZIP:	COUNTY:

5. E-MAIL (Voluntary)	6. DATE OF BIRTH	7. SEX

8. SOCIAL SECURITY NUMBER (Voluntary)	9. DRIVERS LICENSE NUMBER/IDENTIFICATION CARD NUMBER

10. TELEPHONE NUMBERS

DAY:	EVENING:

TRANSFER PROCESS

11. Are you currently registered on TrustLine Registry Program, or licensed by or working in a facility that is licensed by the California Department of Social Services, Community Care Licensing Division? ☐ YES ☐ NO If YES, please list below.

11a. Please provide the Personnel ID (Per ID) number _____

12. Do you want to transfer your background clearance from TrustLine Registry Program or Community Care Licensing facility to the Home Care Aide Registry? ☐ YES ☐ NO If YES, please list below.

Please note: If you elect to transfer, fingerprints are not required; however, you must provide a photocopy of your ID with this application.

12a. Please enter the TrustLine Registry number or facility number transferring from:

HOME CARE ORGANIZATION AFFILIATION

13. Are you currently affiliated to or applying to become affiliated with a Home Care Organization? ☑ YES ☐ NO If YES, please list below.

Home Care Organization Name	Home Care Organization Number
Home Care Organization on the LiveScan form: Heritage Senior Care, INC	374700058

I DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS FORM ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE	DATE

Federal law (at Title 5 United States Code Section 552a Note) states that: Any federal, state, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

CRIMINAL RECORD STATEMENT

State law requires that persons associated with licensed facilities or Home Care Aide Registry applicants be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.

Have you ever been convicted of a crime in California ? . . . . . ☐ YES ☐ NO

You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.

Have you ever been convicted of a crime from another state, federal court, military or jurisdiction outside of U.S.? . . . . . ☐ YES ☐ NO

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

If you answer YES, give details on the back of this page indicating the nature and circumstances of each crime and the date and the location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You had no jail time or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside or the sentence was suspended.

NOTE: IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) WILL RESULT IN AN EXEMPTION DENIAL, LICENSE APPLICATION DENIAL, LICENSE REVOCATION, OR EXCLUSION FROM A LICENSED FACILITY/ORGANIZATION.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.

FACILITY/ORGANIZATION NAME		FACILITY/ORGANIZATION NUMBER	
Heritage Senior Care, INC		374700058	
YOUR NAME *(PRINT CLEARLY)*	YOUR ADDRESS	CITY	ZIP
SOCIAL SECURITY NUMBER *(SEE PRIVACY STATEMENT ON REVERSE SIDE)*	DATE OF BIRTH	DMV LICENSE NUMBER	
SIGNATURE		DATE	

I. Instructions to Respondents:

If you have been convicted of a crime in California, another state or in federal court, provide the following information:

(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.)

What was the offense? _____

In which state and city did you commit the offense? _____

When did this occur? _____

Tell us what happened. (Use additional sheets of paper if needed) _____

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

Signature _____ ***Date*** _____

II. Instructions to Licensees:

If the person discloses a criminal conviction, review the person's statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility/organization personnel file and send a copy to your LPA.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, 1596.871, and 1796.19). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask, the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

REQUEST FOR LIVE SCAN SERVICE - COMMUNITY CARE LICENSING

Applicant Submission

1. ORI: **A0448**

2. Working Title: *(Check ✔ one)*
☐ Adult Resident other than Client ☐ Employee ☐ License, Certification, Applicant ☐ Volunteer ☑ Home Care Aide

3. Authorized Applicant Type - Enter from list on Page 2, "DOJ Abbreviated CCLD Facility/Organization Type."
Home Care Organization

4. Agency Address Set Contributing Agency:

CA Dept of Social Services	**03502**
Agency authorized to receive criminal history information	Mail Code *(five-digit code assigned by DOJ)*
PO BOX 944243 **Mail Station 9-15-62**	**N/A**
Street No. Street or PO Box	Contact Name *(Mandatory for all school submissions)*
Sacramento, CA 94244-2430	( ) **N/A**
City State Zip Code	Contact Telephone No.

5. Applicant Information:

Name of Applicant: *(Please print)* _____ (LAST) _____ (FIRST) _____ (MI)

AKA's: _____ (LAST) _____ (FIRST)

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. BIL - _____ (AGENCY BILLING NUMBER *(IF APPLICABLE)*)

HT: _____ WT: _____

Misc. No.: _____ (PERMANENT RESIDENT (I-551), OUT OF STATE DRIVER'S LICENSE OR I.D.)

EYE Color: _____ HAIR Color: _____

Home Address: *(All applicants must complete)*

POB: _____

_____ (STREET OR PO BOX)

SOC: _____ (See Privacy Statement on Page 4)

_____ (CITY, STATE AND ZIP CODE)

6. Facility/Organization Number: 374700058 Level of Service ☑ DOJ ☑ FBI

If resubmission for fingerprint quality (select R2), list Original ATI No. _____

7. Employer: (*Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only*)

Heritage Senior Care, INC	
Employer Name	
2755 Jefferson Street #101	00696
Street No. Street or PO Box	Mail Code *(five digit code assigned by DOJ)*
Carlsbad, CA 92008	1-800-562-2734
City State Zip Code	Agency Telephone No. *(Optional)*

8.

Live Scan Transaction Completed By: _____ (Name of Operator) Date _____

Transmitting Agency LSID# ATI No. Amount Collected/Billed