



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): _____

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

Cell Carrier: _____

(Such as AT&T, Cingular, T-Mobile, Verizon, etc...)

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 <u>some</u> | ___ | Do you have allergies to pets? Yes ___ No ___ | ___ |
| Cancer | ___ | light housekeeping <u>at least 20%</u>) | ___ | if Yes: Dog ___ Cat ___ Bird ___ | ___ |
| CHF(Congestive Heart Failure) | ___ | Parkinson's | ___ | | |
| Colostomy (empty) | ___ | Shower (stand by assist) | ___ | ► Are you a US Veteran? Yes ___ No ___ | ___ |
| Companionship ONLY | ___ | Stomach Tube (peg-tube) | ___ | ► Are you accepting SNAP benefits? Yes ___ No ___ | ___ |
| Cooking (meal prep) | ___ | Stroke | ___ | ► Are you currently or have you been trained through | ___ |
| COPD (Chronic Obstructive Pulmonary Disease) | ___ | Transfer Board | ___ | WOTC Yes ___ No ___ | ___ |
| Dementia | ___ | Transfer with Assistance | ___ | ESE Yes ___ No ___ | ___ |
| Diabetes | ___ | Wheelchair Transfer | ___ | EDD Yes ___ No ___ | ___ |
| Diapers/Depends | ___ | Walker Assist | ___ | (This ► symbol indicates some financial incentives) | ___ |
| Emphysema | ___ | Are you a smoker? Yes ___ No ___ | ___ | | |
| Hip Replacement | ___ | Will you work with a client who smokes? Yes ___ No ___ | ___ | | |
| | | Will you drive a client in your car? Yes ___ No ___ | ___ | | |
| | | 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.

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

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3. RESIDENCE ADDRESS

STREET:	APT:	CITY:	STATE:	ZIP:	COUNTY:
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4. MAILING ADDRESS (If Different):

P.O. BOX/STREET:	APT:	CITY:	STATE:	ZIP:	COUNTY:
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5. E-MAIL (Voluntary)**6. DATE OF BIRTH****7. SEX**

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

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10. TELEPHONE NUMBERS

DAY:	EVENING:
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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
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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.

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 Heritage Senior Care, INC		FACILITY/ORGANIZATION NUMBER 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 <input checked="" type="checkbox"/> one)			
<input type="checkbox"/> Adult Resident other than Client <input type="checkbox"/> Employee <input type="checkbox"/> License, Certification, Applicant <input type="checkbox"/> Volunteer <input checked="" type="checkbox"/> 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	
Street No. Street or PO Box		Contact Name (Mandatory for all school submissions)	
Sacramento, CA		94244-2430	
City State		Zip Code	
		() N/A	
		Contact Telephone No.	
5. Applicant Information:			
Name of Applicant: (Please print) _____			
LAST		FIRST	MI
AKA's: _____			
LAST		FIRST	CDL No.
DOB: _____		SEX: <input type="checkbox"/> Male <input type="checkbox"/> 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: _____			CITY, STATE AND ZIP CODE
(See Privacy Statement on Page 4)			
6. Facility/Organization Number: 374700058 Level of Service <input checked="" type="checkbox"/> DOJ <input checked="" type="checkbox"/> 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		00696	
2755 Jefferson Street #101		Mail Code (five digit code assigned by DOJ)	
Street No. Street or PO Box		1-800-562-2734	
Carlsbad, CA 92008		Agency Telephone No. (Optional)	
City State		Zip Code	
8.			
Live Scan Transaction Completed By: _____		Date _____	
		Name of Operator	
Transmitting Agency	LSID#	ATI No.	Amount Collected/Billed