NEW CENTURY HOME CARE

EMPLOYMENT APPLICATION

NEW CENTURY HOME CARE considers applicants for employment without regard to race, color, religion, age, sex, sexual orientation, national origin, marital status, disability, veteran status, predisposing genetic characteristics, or any other legally protected status.

Name: (Last)	**(First)**	**(Middle Initial)**
Other Name: (If applicable)		
Address:		**Length of time at this address**
Address:		**Length of time at this address**
Home Phone: ( )	**Cell: ( )**	
Are you legally employable within the United States at this time? Yes ☐ No ☐		
Overtime and irregular hours may be required. Are you available to work overtime? Yes ☐ No ☐		
Are you able to perform the essential functions of the job for which you are applying (with or without reasonable accommodation)? Yes ☐ No ☐ ☐ Need more information about job's essential functions to respond.		

Position applied for: Admin. RN LPN HHA PCA PT/OT/RT MSW Clerical Other

EDUCATION/SCHOOLS ATTENDED	NAME OF SCHOOL AND ADDRESS	DID YOU GRADUATE	COURSE OR MAJOR	DIPLOMA OR DEGREE	NUMBER OF YEARS COMPLETED
High School					
College					
Graduate School					
Business School					
Training Program					

WORK HISTORY

Name, Address and Phone # of Current/Former Employers (List current Last)	From: Mo/Yr	To: Mo/Yr	Job Title	Supervisor's Name	Reason for Leaving

For references purposes, New Century may ___ may not___ contact my present employer.

If not addressed above, have you been fired or asked to resign from a job? Yes ☐ No ☐

ADDITIONAL REFERENCES

NAME	ADDRESS	RELATIONSHIP

EMPLOYMENT APPLICATION (Page 2)

Professional Licenses: **Profession:**	**Lic. No.:**	**Exp. Date:**	**Verification:**
Professional Licenses: **Profession:**	**Lic. No.:**	**Exp. Date:**	**Verification:**
Para-Professional Certification: **School/Training Program:**		**HHA PCA**	**Verification:**
Para-Professional Certification: **School/Training Program:**		**HHA PCA**	**Verification:**

I understand and agree that the information provided in this application will be relied upon by New Century Home Care in considering me for employment.

I certify that all statements made by me on this application are true and complete to the best of my knowledge and that I have withheld nothing that would, if disclosed, affect this application unfavorably. I understand that, if I become employed, falsification of any information provided by me to New Century Home Care could result in termination of my employment.

I understand that past employers, educational institutions, the Department of Motor Vehicles, and/or the military will be contacted for references/records. I specifically authorize such employers, educational institutions, the Department of Motor Vehicles, and/or the military to disclose such information and agree to hold all such persons harmless as a result of any such disclosure.

I understand that this application is current for sixty (60) days and that, if I have not heard from New Century Home Care within such sixty (60) day period and still wish to be considered for employment, it will be necessary to complete a new application.

I understand that satisfactory completion of a criminal background check, medical examination, and/or drug test, is a condition of employment and that applicants to whom a conditional offer of employment has been made will be required to sign an authorization for a criminal background check, submit to a medical examination and/or drug test. I further understand that refusal to sign an authorization for a criminal background check or submit to a medical examination or drug test, or failure to appear or cooperate in connection with the medical examination or drug test will preclude employment with New Century Home Care and that, if there is evidence of current use of illegal drugs, I will not be employed at New Century Home Care.

I also understand that if I am employed, I will be required to provide satisfactory proof of identity and legal work authorization within three (3) days of being hired. Failure to submit such proof within the required time shall result in immediate termination of employment.

I understand that this offer is contingent upon my acceptance of the terms and conditions of employment established by New Century Home Care, which may be changed from time to time in the discretion of New Century Home Care.

I understand that unless provided otherwise in an employment agreement or collective bargaining agreement, any employment relationship with New Century Home Care is of an "at will" nature, which means that either I or New Century Home Care may terminate my employment, with or without cause, at any time for any lawful reason.

Applicant's Signature _____ **Date** _____

40214

DOH CHRC 104 (9/06)

NYS Department of Health

EXPEDITED REVIEW REQUEST FORM FOR CRIMINAL HISTORY RECORD CHECK

DOH use only. Leave Blank

This form is to be submitted to the DOH CHRC Unit to secure the CHRC employment determination for subject individuals seeking employment with this Agency and who have previously been fingerprinted on or after 9/1/06.

For purposes of this form, the term "**Agency**" means residential health care facility, certified home health agency, licensed home care services agency or long term home health care programs that are authorized by law to request a check of criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law. "**Authorized Person**" is the individual that is allowed to request, on behalf of the Agency, fingerprints and criminal history record checks. "**Subject individual**" is an "employee" as defined by Public Health Law Section 2899(3).

Type or print all information - USE CAPITAL LETTERS.
Inaccurate, incomplete or illegible information will delay processing.

Instructions:

1. Please complete all fields on this form
2. Subject individual is required to present two (2) forms of identification when form is completed. One must be a government issued Photo ID with subject individual's signature which will be recorded in Section 2. Acceptable forms of ID (with your photo and signature) are: valid driver's license or DMV ID, valid passport, valid military identification or valid school identification document. The type of government issued ID presented is recorded in Section 2 of this form. Refer to the Employment Eligibility Verification Form I-9 for examples of secondary forms of identification.
3. This form must be signed and dated where indicated in Section 3 by the Agency Authorized Person.
4. This form must be forwarded to the DOH CHRC Unit.

SECTION 1 - SUBJECT INDIVIDUAL INFORMATION

Social Security Number* ___ - ___ - ____ Date of Birth mm/dd/yyyy __ / __ / ____

LAST Name _____ FIRST Name _____ M.I. _

Maiden Name _____ Alias (AKA) _____

Street Number _____ Street Name _____ Apt number _____

City _____ St __ Zip _____ Home Phone ___ - ___ - ____

Sex _ Birth Country/Place _____ Cell Phone ___ - ___ - ____

Race _ Height (ft-inch) _ - __ Weight (lbs) ___ Hair ___ Eyes ___

SECTION 2 - SUBJECT INDIVIDUAL IDENTIFICATION

Please Select the Type of **PICTURE IDENTIFICATION** (select one):

○ Drivers License/ DMV ID ○ Passport ○ Miltary ○ School ○ Other Identify: _____

Issuing State/Country/Armed Force/School: _____ ID Number _____ ID Expire Date mm/dd/yy __ / __ / __

SECTION 3 - AGENCY IDENTIFICATION

○ Nursing Home ○ CHHA ○ LTHHCP PFI# ____ ○ LHCSA LICENSE # _____

Full name of Agency where applicant will be working _____ Telephone number with area code ___ - ___ - ____

Authorized Person LAST Name _____ FIRST Name _____

Street Number _____ Street Name _____

City _____ State __ Zip _____

Authorized Party's e-mail: _____

The subject individual, whose identification I have confirmed, will provide direct care or supervision to individuals receiving care and/or services and is a subject individual concerning whom a criminal history record check is required by law (Article 28-E of the Public Health Law and Section 845-B of the Executive Law). I understand that the results of the criminal history record check will be used solely for purposes authorized by law and I will abide by the confidentiality requirements set forth in law. Informed consent (DOH CHRC Form 102) has been given by the subject individual and is on file.

Signature of Agency Authorized Person: _____ Date: __ / __ / __
MM DD YY

40214

*The Authorized Person shall inform the subject individual that disclosure of the Social Security Number (SSN) is vountary and not mandatory and that it will be used to assist DOH CHRC Unit in performing criminal history record checks.

DOH CHRC 102 (1/07)

NYS Department of Health

ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION

THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.

chrc@health.state.ny.us

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

Mailing Address (street)	City	State	Zip

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 to be provided 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, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. 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.

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.

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 have 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 redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. 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 (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: _____ Date: _____

Signature of Parent or Legal Guardian_____ Date: _____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

NEW CENTURY HOME CARE, INC.

1410 EAST 10TH STREET * BROOKLYN, NY 11230
PHONE (718) 998-2100 * FAX (718) 998-2951

REFERENCE RELEASE FORM

APPLICANT NAME (PRINT) : _____
FIRST NAME LAST NAME

CURRENT/FORMER EMPLOYER: _____

SS# (Last 4 digits only): _____ DATES EMPLOYED: FROM _____ TO _____
MONTH/YEAR MONTH/YEAR

The above-named applicant is being considered for employment with New Century Home Care and has listed your organization as an employer (current/former). We would appreciate your verification and completion of this form at your earliest convenience. Please fax or mail to New Century Home Care as soon as possible. Thank you for your assistance.

APPLICANT AUTHORIZATION

I consent to and authorize the above-named current/former employer, and its agents and employees, to furnish any reference information regarding me, including achievement, wage history, performance, attendance, personal history, disciplinary information and reason for separation of employment, relating to my employment with the current/former employer. It is expressly understood that nay information given is to be used for the purpose of determining my acceptability for employment. I also hereby release the above-named current/former employer, and its agents and employees, from all liability for damages or claims, including but not limited to defamation, interference with contract, or prospective economic advantage or negligence I have or may have which arise or result from any reference information provided pursuant to this authorization or any attempts to comply with this information.

APPLICANT SIGNATURE: _____ _____/_____/_____
DATE

RECORD OF EMPLOYMENT

POSITION HELD: _____ EMPLOYED: FROM: _____ T0 _____
MONTH/YEAR MONTH/YEAR

SUMMARY OF ESSENTIAL DUTIES: _____

_____

REASON FOR LEAVING: _____

SALARY AT TERMINATION: _____ ELIGIBLE FOR RE- EMPLOYMENT?: [ ] YES [ ] NO

PLEASE RATE THE CANDIDATE AS FOLLOWS:

	EXCELLENT	GOOD	AVERAGE	FAIR	POOR
JOB KNOWLEDGE					
ACCURACY					
PRODUCTIVITY					
DEPENDABILITY					
ATTENDANCE					
OVERALL PERFORMANCE					

COMMENTS: _____

SIGNATURE: _____ _____ _____/_____/_____
TITLE DATE

NEW CENTURY HOME CARE, INC.
1410 EAST 10TH STREET * BROOKLYN, NY 11230
PHONE (718) 998-2100 * FAX (718) 998-2951

Date:_____

Dear: _____Company: _____Title: _____

The person referred to below has applied for a position at New Century Home Care, Inc.Would you kindly fill in the blanks below and return the reference/information requested.

Thank you

Name of Applicant: √			
Soc.Sec.# (Last 4 Digits only)			
Position applied for: √			
APPLICANT'S RECORD WITH YOU:	**SATISFACTORY**	**UNSATISFACTORY**	**UNABLE TO EVALUATE**
Attendance Record			
Appearance			
Initiative			
Cooperative			
Dependabillity			
Accepts constructive criticism			
ADDITIONAL COMMENTS:			
Signature/Title:		**Date:**	
APPLICANT RELEASE OF INFORMATION: **I hereby release from all liability the company, institution or person named above and authorize them to release all information regarding my employment with them.**			
APPLICANT SIGNATURE: √		**Date: √**	