

## SeniorCare Companions, Inc. Employment Application

First Name \_\_\_\_\_ Last \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ EMAIL: \_\_\_\_\_

Cell # ( ) \_\_\_\_\_ Text messaging?  Yes  No Home # ( ) \_\_\_\_\_

**PLEASE CHECK THE NAME OF YOUR CELL PHONE COMPANY FOR JOB ALERTS (required)**

AT&T  Verizon  T-Mobile  Sprint  MetroPCS  Boost  Other \_\_\_\_\_

EDUCATION:  High School  College  Trade School Are you a U.S. Veteran?  Yes  No

Are you a previous employee of SeniorCare Companions?  Yes  No

**How were you referred to this agency?** \_\_\_\_\_

### **EMPLOYMENT AVAILABILITY: PLEASE CHECK ALL THAT APPLY**

Hourly days  Hourly evenings  Live-in  Overnights When can you start working? \_\_\_\_\_

Please check the *days and times* you are available to work:  Mon \_\_\_\_\_  Tues \_\_\_\_\_  Wed \_\_\_\_\_

Thurs \_\_\_\_\_  Fri \_\_\_\_\_  Sat \_\_\_\_\_  Sun \_\_\_\_\_

**Please check one:**  Driver license  Driver permit  None Do you have a car that you can use for work?  Yes  No

How many miles are you willing to travel for work? \_\_\_\_\_  Nassau  Suffolk  Other \_\_\_\_\_

**Do you have any restrictions when it comes to lifting or weight bearing?**  Yes \_\_lbs.  No Do you smoke?  Yes  No

Can you work in a home with pets?  Yes  No \_\_\_\_\_ Do you have any allergies?  Yes  No Type: \_\_\_\_\_

Do you have any Certification?  Yes  No Please specify:  PCA  HHA  CNA  LPN  RN  Other \_\_\_\_\_

Languages Spoken:  English  Spanish  French  Italian  Russian  Sign  Other \_\_\_\_\_

**Are you legally authorized to work in the United States?**  Yes  No

*(please check one)*  I am a U.S. Citizen  Permanent Resident  Work Authorization

### **OFFICE USE ONLY**

Application  I.D.  Health Status Form Hired:  Yes  No  Criminal Background  References \_\_\_\_\_

Interview notes: \_\_\_\_\_

**ORIENTATION DATE:** \_\_\_\_\_  Will Attend  Future  Re-schedule \_\_\_\_\_

**TRAINEE:**  Photo  Policies and Procedures  Job Description

**CASE FILE DAY:**  W-4  I-9  Bank Info.  Wage Agreement  Finger Prints **EMPLOYEE I.D. #** \_\_\_\_\_

Badge  Uniform  Employee Manual  Policies and Procedures  Patti Policy

**MEDICAL:**  Physical Exam  Drug Test  PPD  Chest x-ray  MMR's Influenza:  Shot  Waiver (signed)

**MISSING DOCUMENTS:** \_\_\_\_\_

**PLEASE NOTE:**

**SUBMITTING FALSE DOCUMENTS OR INFORMATION ON YOUR APPLICATION IS STRICTLY PROHIBITED**

**EMPLOYMENT HISTORY:** Please list your employment within the past five years, *most recent first*.

**\*Please include an address and phone number**

1. Employer \_\_\_\_\_ Phone# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Position Held: \_\_\_\_\_ Salary \_\_\_\_\_ Contact or Supervisor \_\_\_\_\_  
Started Employment: \_\_\_\_\_ Ended Employment: \_\_\_\_\_  
Reason for leaving \_\_\_\_\_ May we call for a reference?  Yes  No

2. Employer \_\_\_\_\_ Phone# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Position Held: \_\_\_\_\_ Salary \_\_\_\_\_ Contact or Supervisor \_\_\_\_\_  
Started Employment: \_\_\_\_\_ Ended Employment: \_\_\_\_\_  
Reason for leaving \_\_\_\_\_ May we call for a reference?  Yes  No

**ADDITIONAL REFERENCES:** *Example: Pastor, Doctor, Lawyer, Teacher, Councilor, Nurse, or Professional*

**\*PLEASE DO NOT LIST FRIENDS OR FAMILY MEMBERS AS REFERENCES**

1) Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address: \_\_\_\_\_ Years Known: \_\_\_\_\_  
2) Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address: \_\_\_\_\_ Years Known: \_\_\_\_\_

**AUTHORIZATION FOR CRIMINAL BACKGROUND CHECK**

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Month) (Day) (Year)

Current address \_\_\_\_\_

Previous Address \_\_\_\_\_

Have you ever been convicted of a crime?  Yes  No If yes, please give dates and explain:

\_\_\_\_\_  
\_\_\_\_\_

NYS Drivers License # \_\_\_\_\_ Out of State Drivers License # \_\_\_\_\_

**I authorize *SeniorCare Companions* to perform a criminal background check. I understand that if I am employed, and if any statement herein is not true, I will be released immediately. If I am released for either of these reasons, I will be paid only through the day of release. My signature below warrants that the foregoing information is true to the best of my knowledge.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**AUTHORIZATION TO RELEASE INFORMATION**

**I authorize *SeniorCare Companions* to obtain the following information:**

- Prior Employment Information from any and all prior employers
- Criminal Background Information
- Medical Information related to my ability to perform as a *SeniorCare Companion*

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**I understand that *SeniorCare Companions* is an employment agency and that work is assigned per-diem based on case availability. I further understand that I am not guaranteed employment with my application and that the decision to hire is based upon the discretion of the agency.**

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

152 Islip Ave, Suite 25, Islip, NY 11751  
Phone (631) 581-9000 Fax (631) 277-4311  
[www.seniorcarecompanions.com](http://www.seniorcarecompanions.com)

# SeniorCare Companions, Inc

## Applicant Health Status

Name: \_\_\_\_\_

A. Are you currently under the care of a physician?  Yes  No

If yes, please explain \_\_\_\_\_

Physician's Name \_\_\_\_\_

B. Are you currently on any medications?  Yes  No

List all Medications \_\_\_\_\_

C. Are you involved in habitual use of or addiction to such substances as depressants, stimulants, narcotics, alcohol or other drugs?  Yes  No

D. Do you smoke?  Yes  No How many packs per day? \_\_\_\_\_

E. Have you had any illnesses, operations, or injuries in the past year?

Yes  No If yes, please explain \_\_\_\_\_

F. Do you have any problems with lifting, balance, bending, or reaching?  Yes  No

If yes, please explain \_\_\_\_\_

G. Have you ever had a Workers Compensation Case for a work injury?

Yes  No  If yes, please explain \_\_\_\_\_

H. Do you have any allergies?  Yes  No List \_\_\_\_\_

I. In the past 6 months have you experienced any of the following symptoms:

*(Check only those that apply)*

Chronic cough that brings up thick, cloudy, or bloody mucus?

Excessive Fatigue and weight loss?

Night sweats and fever?

Rapid Heartbeat?

Swelling in the neck?

Shortness of breath and chest pain?

Severe neck or back pain?

J. Can you provide documentation (current, within 1 year) of the following?

Physical exam  PPD or chest x-ray  Drug test

Signature \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_



# SeniorCare Companions, Inc.

“Quality Care You Can Trust”

**COMPANION JOB DESCRIPTION FORM – Please read and sign below**

**Requirements:** Must be a loving and kind individual that can provide quality care that our clients can trust ♥

**Companion Duties:**

**Communication with the office is key!** If there is any change in the clients’ condition, or if there is any change in the schedule, you must notify the office immediately.

- Your primary job is to provide companionship and care for the needs of the client, and to make sure that the environment is safe. Some light housekeeping is involved, but should only be about 20% of the work day.
- Supervise showering and toileting for safety. You may not bathe client unless you have certification to do so.
- Remind and assist with medications. Keep a log of medications given, as well as any change in patient’s condition. **If there is a change in the patient’s condition, report this to the office.**
- Prepare nutritious meals and snacks, as per the client *and* office direction.
- Assist the client in making a grocery list, and shop for the groceries, if required. Remember to get receipts.
- Always provide adequate liquids. Always have food and drinks available for the client when you leave.
- Keep the client’s home neat and clean. Duties may include sweeping, vacuuming, mopping, dusting, surface cleaning, especially in the kitchen and bathroom areas. Always inform the office with any problems with the client’s home environment.
- Keep clean sheets on the bed and clean towels in the bathroom. Be sure to do the client’s laundry regularly. Wash, dry, fold and put away clothes regularly, as needed.
- Remind the client, if needed, to change clothes daily and always have clean clothes ready for them.
- Escort the client to and from appointments, if required.
- Encourage activities within their limitations, such as: family gatherings, errands and trips to the store, visiting friends, or crafts.
- Be aware of safety issues, such as assisting the client when walking, if unsteady. All unsafe conditions must be reported to the office as soon as they are discovered.

**Companions may NOT do the following:**

- You may not *administer* medication to your client. You may only remind them to take their medication.
- You may *never* involve yourself in your client’s finances.
- You may not smoke while on duty.
- You may not use the client’s phone except to log in and out, contact the office, or to report an emergency.
- Non-emergency personal calls and texting, or use of computer/internet while on duty is prohibited.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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*“Quality Care You Can Trust”*

## HOME CARE EXPERIENCE

(Please check all that apply)

### PERSONAL CARE

Bathing[] Bed/sponge bath[] Shower assist[] Skin care[] Oral care[]  
Shampoo[] Shave[] Assist w/dressing & undressing[]

### HOUSEKEEPING

Vacuuming[] Sweeping[] Dusting[] Change bedding[] Laundry[] Wash dishes[] Dishwasher[]

### COOKING

Meal preparation[] Assist w/feeding[] Special diets[]

### ERRANDS

Grocery shopping[] Personal shopping[] Medical appointments[] Drive w/client[]

### SAFETY

Universal Precautions[] Fall prevention[] Seizure precautions[]

### MOBILITY ASSISTANCE

Assist w/walking[] Walker[] Wheelchair[] Transfers[]

### ALZHEIMER’S AND DEMENTIA CARE []

### MEDICAL REMINDERS []

INTERVIEWED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

NOTES:

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150 Route 111, Suite 2, Islip NY 11751

Phone: 631-581-9000

**Please return ASAP to**

**Fax # 631-277-4311**



## **FAX Reference Form**

**Company:** \_\_\_\_\_ **From:** *Holly Pickardo - HR*  
**Attention:** \_\_\_\_\_ **Pages:** \_\_\_\_\_  
**Fax ( )** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Re:** EMPLOYMENT VERIFICATION **CC:** \_\_\_\_\_

***Please fax this form ASAP for expedited processing of prospective employee:*** \_\_\_\_\_

*The above named has applied for a position with our agency and has listed you as a previous employer. Please confirm dates of employment and any additional information, as policy allows. All information provided will be kept strictly confidential.*

### **APPLICANT SIGNATURE TO RELEASE INFORMATION:**

X \_\_\_\_\_ S.S.# xxx-xx- \_\_\_\_\_

- **Dates of Employment:** from \_\_\_\_\_ to \_\_\_\_\_
- **Would you consider rehiring this individual?**  Yes  No

**Comments:** \_\_\_\_\_

**Reference Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_