OLIVER HOME HEALTHCARE AGENCY, LLC
APPLICATION FOR EMPLOYMENT

Note: Applicants will be tested for illegal drugs.

Date of Application __________
Date of Hire: __________

PLEASE PRINT LEGABLY ALL INFORMATION REQUESTED EXCEPT SIGNATURE
AND COMPLETE ALL QUESTIONS OR STATE "N/A" IF NOT APPLICABLE.

PERSONAL INFORMATION:

Name: ____
Last First Middle

Present Address: ____
Address City State Zip

Social Security Number: _______ - ____ - _______ Cell Number: (_____) ____________________

Home Number: (_____) ____________________

If under 18 please list age: _______________. How did you hear about OHHC? ____________________

Are you applying for position of Attendant Provider? ☐YES ☐NO If you checked NO, What position are you applying for? ______________________________ How many hours a week can you work? ________

Days and Hours available to work (circle all days that apply and document hours):

No Preference: ________ *Sunday:* ____________ *Monday:* ____________ *Tuesday:* ____________

Wednesday: ____________ *Thursday:* ____________ *Friday:* ____________ *Saturday:* ____________

Can you work nights? _____________. What date are you available to start working? ________________

EDUCATION: Check all that apply.

High School Diploma ______ GED______ College ______ Business/Trade School ______

HAVE YOU EVER BEEN CONVICTED OF A CRIME? (We do perform Background Checks) ☐YES ☐NO

If yes, explain number of conviction(s), nature of offense(s), leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) and type(s) of rehabilitation.

____

____

APPLICATION CONTINUED

WORK EXPERIENCE: *(You may skip this section if you have attached a resume)*

Please list your work experience for the past 3 years beginning with your most recent job held. If you were self-employed, give firm name. Attach additional sheets if necessary.

Name of Employer: ______________________________ ***Employment Dates:*** ____________________

Address: ______________________________ ***Position Held:*** ____________________

City, State Zip: ______________________________ ***Duties:*** ____________________

Phone Number: ______________________________ ***Name of Supervisor:*** ____________________

Reason for Leaving: *(please be specific)*

____

____

Name of Employer: ______________________________ ***Employment Dates:*** ____________________

Address: ______________________________ ***Position Held:*** ____________________

City, State Zip: ______________________________ ***Duties:*** ____________________

Phone Number: ______________________________ ***Name of Supervisor:*** ____________________

Reason for Leaving: *(please be specific)*

____

____

Name of Employer: ______________________________ ***Employment Dates:*** ____________________

Address: ______________________________ ***Position Held:*** ____________________

City, State Zip: ______________________________ ***Duties:*** ____________________

Phone Number: ______________________________ ***Name of Supervisor:*** ____________________

Reason for Leaving: *(please be specific)*

____

____

APPLICATION FORM WAIVER: *(Please read carefully and sign below)*

In exchange for the consideration of my job application by OLIVER HOME HEALTHCARE AGENCY LLC, (herein after called "the Agency"), I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship either in the position applied for or any other position, and regardless of the contents of employee handbooks personal manuals, benefit plans, policy statements, and the like as they may exist from time to time, or other Agency practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of the Agency, or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the owner or administrator of the Agency. Both the undersigned and the Agency may end the employment relationship at any time without specified notice or reason. If employed, I understand that the Agency may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for4 is cause for dismissal at any time without any previous notice. I hereby give the Agency permission to contact schools, previous employers (unless otherwise indicated), references etc... And I hereby release the Agency from any liability as a result of such contact.

I further understand that my employment with the Agency shall be probationary for a period of sixty (60) days and further that at any time during the probationary period or thereafter my employment relation with the Agency is terminable at will for any reason by either party.

Signature of Applicant: ______________________________ Date: ____________________

This Agency is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with this Agency depends solely on your qualifications.

REFERENCE VERIFICATION FORMS: (We *must have two* references – One reference can be of Personal nature)

Check one: ☐ Professional

I, ________________________________ Date: ______________ give my permission to release any/all information concerning my work relationship to ***Oliver Home Healthcare Agency***.

I was employed with____(Company/Agency)

From _______________ to _______________ and my position was ___________________. My duties included ____

____

My reason for leaving is: ____

____

Phone Number: (   ) ______________ Fax: (   ) ______________.

APPLICANT ***Please Do not write below this line - for Office use only***

Reference Given By: ______________________________ **Title:** ______________________

Quality of work:	☐ Excellent	☐ Above Average	☐ Average	☐ Unacceptable
Communication Skills	☐ Excellent	☐ Above Average	☐ Average	☐ Unacceptable
Interpersonal Skills	☐ Excellent	☐ Above Average	☐ Average	☐ Unacceptable
Professional Competency	☐ Excellent	☐ Above Average	☐ Average	☐ Unacceptable
Dependability	☐ Excellent	☐ Above Average	☐ Average	☐ Unacceptable

Reason for Termination?____

Dates Employed: From_______________ **to** _______________ **Eligible for rehire?** ☐ **YES** ☐ **NO**

Comments: ____

____

____

Reference Taken By: ______________________________ **Date:** ______________________

REFERENCE VERIFICATION FORMS: (We *must have two* references – One reference can be of Personal nature)
Check one: ☐ Personal

I, ________________________________ Date: ______________ give my permission to release any/all information concerning my relationship to ***Oliver Home Healthcare Agency***.

Name of reference ____

Time known_______________ and relationship ______________________________

Phone Number: ( ) _______________

APPLICANT ***Please Do not write below this line - for Office use only***

Reference Given By: ________________________________ **Title:** ______________________

Quality of work:	☐ Excellent	☐ Above Average	☐ Average	☐ Unacceptable
Communication Skills	☐ Excellent	☐ Above Average	☐ Average	☐ Unacceptable
Interpersonal Skills	☐ Excellent	☐ Above Average	☐ Average	☐ Unacceptable
Professional Competency	☐ Excellent	☐ Above Average	☐ Average	☐ Unacceptable
Dependability	☐ Excellent	☐ Above Average	☐ Average	☐ Unacceptable

Reason for Termination?____

Dates Employed: From_______________ **To** _______________ **Eligible for rehire?** ☐ **YES** ☐ **NO**

Comments: ____

____

____

Reference Taken By: ________________________________ **Date:** ______________________

CRIMINAL HISTORY CHECK: NOTIFICATION AND STATEMENT OF EMPLOYABILITY

I acknowledge that I have been informed by the Agency that a criminal history and Employee Misconduct or Nurse Aide Registry check will be performed on my name. I have informed this Agency of all names (for example, maiden name, aliases) that I have used in the past. I understand that if I have been employed on an emergency basis that my employment is temporary pending the results of the criminal history check. I also understand that if I have been listed in either registry or convicted of the following offenses, that I cannot be employed by this Agency.

A. *I have not ever been convicted of the following crimes:*

- An offense under Chapter 19, Penal Code (criminal homicide);
- An offense under Chapter 20, Penal Code (kidnapping and unlawful restraint);
- An offense under Section 21.02, Penal Code (continuous sexual abuse of a young child or children);
- An offense under Section 21.11, Penal Code (indecency with a child);
- An offense under Section 22.011, Penal Code (sexual assault);
- An offense under Section 22.02, Penal Code (aggravated assault);
- An offense under Section 22.04, Penal Code (injury to a child, elderly individual or disabled individual);
- An offense under Section 22.041, Penal Code (abandoning or endangering a child);
- An offense under Section 22.08, Penal Code (aiding suicide);
- An offense under Section 25.031, Penal Code (agreement to abduct from custody);
- An offense under Section 25.08, Penal Code (sale or purchase of a child);
- An offense under Section 28.02, Penal Code (arson);
- An offense under Section 29.02, Penal Code (robbery);
- An offense under Section 29.03, Penal Code (aggravated robbery);
- An offense under Section 21.08, Penal Code (indecent exposure);
- An offense under Section 21.12, Penal Code (improper relationship between educator and student);
- An offense under Section 21.15, Penal Code (improper photography or visual recording);
- An offense under Section 22.05, Penal Code (deadly conduct);
- An offense under Section 22.021, Penal Code (aggravated sexual assault);
- An offense under Section 22.07, Penal Code (terroristic threat);
- An offense under Section 33.021, Penal Code (online solicitation of a minor);
- An offense under Section 34.02, Penal Code (money laundering);
- An offense under Section 35A.02, Penal Code (Medicaid fraud);
- An offense under Section 36.06, Penal Code (obstruction or retaliation);
- An offense under Section 42.09, Penal Code (cruelty to livestock animals); or under Section 42.092, Penal Code (cruelty to nonlivestock animals); or
- A conviction under the laws of another State, Federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed in this section, and
- An offense that the Agency determines to be a contra-indication to employment with the consumers the Agency serves.

B. *I have not been convicted of the following crimes within five years of this date:*

- An offense under Section 22.01, Penal Code (assault), that is punishable as a Class A misdemeanor or as a felony.
- An offense under Section 30.02, Penal Code (burglary);
- An offense under Chapter 31, Penal Code (theft), that is punishable as a felony:
- An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or as a felony,
- An offense under Section 32.46, Penal Code (securing execution of a document by deception), that is punishable as a Class A misdemeanor or a felony,
- An offense under Section 37.12, Penal Code (false identification as a police officer); or
- An offense under Section 42.010 (a), (7), (8) or (9), Penal Code (disorderly conduct).

List any other states previously lived in the past 7yrs:______________________________

I understand that all information obtained by this Agency regarding my criminal history will remain confidential. I certify that the information on this form contains no willful misrepresentation and that the information is true and complete to the best of my knowledge.

Applicant Signature: ______________________________ Date: ____________________

Print Name: ____

DISCLOSURE OF DRUG TESTING

POLICY

The Agency will provide a written statement describing the Agency's policy for drug testing of employees who have direct contact with Clients to each person applying for services from the Agency and any person requesting the information.

The Agency recognizes its responsibility to protect its' employees and Clients from the dangers posed by the use of illegal drugs, misuse of controlled substances and the effects of alcohol use in the office or in the home setting. Employees who illegally use drugs, misuse drugs or use alcohol on the job create a serious risk to the safet7, security and health of themselves, other employees and Clients.

- In compliance with state and federal law, the Agency forbids any illegal or improper use of drugs and/or alcohol by its employees while on duty. (On duty includes rest periods, meal breaks and on-call hours).
- The Agency forbids selling, dispensing, distributing, possessing or manufacturing drugs, drug paraphernalia, alcohol or controlled substances during work hours or during any work–related activities.
- Any employee who is found to have violated this policy will be disciplined or terminated.
- An exception to this policy covers any employee who, under the direction of a physician, is taking prescribed medication while at work, while using agency equipment, while conducting agency business or while on breaks. In this circumstance, it is the responsibility of the employee to report the use of the prescribed medication that might affect job performance before job performance is actually impaired.

PROCEDURE – At will testing:

The Agency does test for drugs or alcohol as a condition for employment. Also, the Agency may at will request an employee to submit to a drug and or alcohol test if the employee is suspected of being under the influence of such. The Agency will not tolerate such use or possession of. The Agency reserves the right to require a drug screen and/or alcohol use. Alcohol or drug use may be evidenced by odor of Alcohol or drugs on the employee's breath or by inappropriate behavior or performance on the job. Testing may also be done after a work-related accident.

PRESCRIPTION MEDICATIONS

If the employee is on a prescription medication, it is the employee's duty to report the use of prescribed medication that might affect job performance before job performance is actually impaired. Reporting or excuses "After the fact" are not sufficient to limit or modify disciplinary or remedial action taken. For the purpose of this policy, individuals who report to work or perform work while impaired or under the influence of a prescribed medication, the usage of which has not been reported previously, will be treated as having reported to work impaired or under the influence of a drug, and thus in violation of the policy.

EMPLOYEE ASSISTANCE

Employees in need of assistance in dealing with alcohol or drug related problems are encouraged to seek professional help prior to the necessity for application of this policy and corresponding procedure. Any employee who violates the above prohibitions will be subject to termination of employment or other relationship with the Agency or, at the Agency's sole discretion, be required to satisfactorily participate in a drug and/or alcohol abuse assistance or rehabilitation program.

METHOD BY WHICH DRUG TESTING IS CONDUCTED

The method for drug testing will be either by urine, blood or breathalyzer data.

Oliver Company

EMPLOYEE INFORMATION FORM

Employee Name: ____
Last First Maiden

Contact Number: **Home:** ( ) ______________________
Cell: ( ) ______________________
Other: ( ) ______________________

Email Address: ______________________ @ ______________________ .com
please print legibly

Physical Address: ____
Street Address City State/Zip

Emergency Contacts: (Please submit at least 2)

Name: ______________________
Phone Number: ______________________
Relationship: ______________________

Name: ______________________
Phone Number: ______________________
Relationship: ______________________

Name: ______________________
Phone Number: ______________________
Relationship: ______________________

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, ______________________________, have been notified that a computerized criminal
APPLICANT or EMPLOYEE NAME (Please print)

history (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB information I supply.

Because the name based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization (as listed below) conducting the criminal history check is not allowed to discuss any information obtained using this method, therefore the agency may offer the opportunity to have a fingerprint search performed to clear any misidentification based on the name search, if the search provides a criminal report I know could not be mine.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from this agency, make an online appointment, submit a full and complete set of my fingerprints, and pay a fee of $9.95 to the fingerprinting services company, L1Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

____
Signature of Applicant or Employee

____
Date

Oliver Home Healthcare Agency
Agency Name (Please print)

John C. Oliver III
Agency Representative Name (Please print)

____
Signature of Agency Representative

____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES ☐ NO ☐ ______ initial

Purpose of CCH: ______

Hire ☐ Not Hired ☐ ______ initial

Date Printed: ______ initial

Destroyed Date: ______ initial

Retain in your files