



Assisted Living in Your Home

PRE-PLACEMENT REQUIREMENTS

This checklist consists of the *minimum requirements* for agency accreditation in our industry. Your documentation and licensing must always be kept current.

All documentation listed below must be current and in our office prior to our granting you an interview and/or orientation. You may hand deliver, email or postal mail your completed application and required documents.

MUST HAVE AT LEAST 2 YRS. CAREGIVER EXPERIENCE. REFERENCES REQUIRED.

Current Driver's License or State I.D. Card

Signed Social Security Card (*Must present ORIGINAL signed card at our office. We will copy and return your original.*)

Any State and Local license(s) (*if applicable*)

(*Certified Nursing Assistant, Personal Care Assistant, Home Health Aide, Certified Medical Assistant, Licensed Practical Nurse, Registered Nurse*)

T.B. Test Results *Must be current (within the last 6 months and renewed every 3 years)*

Ruth Fertel Tulane Clinic (504) 609-3500 - 711 N. Broad Street, New Orleans (\$20)

Walgreens Take Care Clinics – (only at select Walgreens stores — not available at all locations) (\$28)

Concentra Medical (504) 283-2273 – 4015 Jeff. Hwy Jefferson, LA (\$27)

Daughters of Charity (ALL LOCATIONS) (504)207-3060 – S. Carrollton Ave. NOLA (\$10)

Pelican Urgent Care (985) 645-9000 – 1525 Dickory Ave. Harahan, LA (\$25)

*******Other TB testing locations and pricing information available upon request. *******

OPTIONAL: At this time, the Caregiver Registry Standards Board is not requiring a C.P.R. card except for child care services. A C.P.R. card is highly recommended.

National Criminal Background Check (*Must be renewed every 3 years*). The cost is \$27.

Drug Test (oral exam). The cost is \$7.

- **National Criminal Background checks are the ONLY type of criminal background checks accepted.**
- ***Dependable is an authorized vendor to process National Criminal Background checks & Drug Test screens.***

➤ALL DOCUMENTATION MUST BE SUBMITTED IN OUR OFFICE BEFORE YOUR APPLICATION WILL BE CONSIDERED/REVIEWED

➤APPLICATIONS ARE ELIGIBLE FOR PICK UP & DROP OFF ON TUESDAYS AND WEDNESDAYS BETWEEN 10AM-2PM◀

➤INCOMPLETE APPLICATIONS ARE HELD FOR *ONLY 45 DAYS* ◀

Referral Application for Independent Contractors

Please print all of your information clearly.

Name: Last _____ First _____ M.I. _____

Mailing Address: _____ Apt.: _____ D.O.B.: ____/____/____

City: _____ State: _____ Zip: _____ How Long: _____

Home Ph: _____ Cell Ph: _____ Other Ph: _____

(If you have resided at a different address within the last 5 years, then please list the previous address below)

Attach additional sheets if necessary.

Previous Address: _____

City: _____ State: _____ Zip: _____ Period of Time Lived There: _____

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City: _____ State: _____ Zip: _____ Period of Time Lived There: _____

Previous Address: _____

City: _____ State: _____ Zip: _____ Period of Time Lived There: _____

Date Available to Start: _____ Referred By: _____

Cell Phone Carrier: AT&T Verizon T-Mobile Sprint Boost **Other:** _____

Email: _____ Marital Status: _____ Soc. Sec.: _____

Name of Your Company: _____ EIN: _____

Have you ever been referred by Dependable before? YES NO If yes, give dates: _____

Do you have any friends or relatives referred by this agency? YES NO If yes, name: _____

Are you a smoker? YES NO Do you have a vehicle? YES NO Is the vehicle a: CAR SUV TRUCK VAN

Are you interested in being a child care worker? YES NO If so, are you Child/Infant CPR Certified? YES NO

Will you work with cats on the premises? YES NO If no, why not: _____

Will you work with dogs on the premises? YES NO If not, why not: _____

Have you ever been convicted of a crime other than a minor traffic violation? YES NO

If YES, please explain: _____

Have you worked under any other names (maiden name, nickname, etc.) that would help us check your work record? _____

What makes this particular type of work appealing to you? _____

Emergency Contact(s): (Name and Number)

Name: _____

Number: _____

Please indicate the locations in which you are able to be referred: (Check all that apply)

Abita Springs Chalmette Covington Kenner Lacombe Madisonville Hammond

Mandeville Metairie New Orleans Slidell Westbank Laplace Picayune, MS Mississippi (certain areas)

Indicate the times you are seeking on a regular basis: (Check all that apply)

Day Shift: 7a – 3p 7a – 5p 7a – 7p **Evenings:** 3p – 11p 7p – 7a 4p – 12a ANYTIME

Rotating weekends

Holidays

Any 4 hours in the morning

Other Times Available: _____

Preferences: Check all that apply

- Would you work in:** Private Home Nursing Home Hospital Assisted Living Center
- Have experience with:** Peg Tubes Catheters Hoyer Lifts Lifting Patients (with little/no asst.)
- Paralyzed Patients Psych Patients Alzheimer's Patients Dementia
- Hospice Care Parkinson's Colostomy Bag Diabetes Care
- Trach Tubes Placing Patients in Wheelchair Blood Pressure Monitoring (manual/digital)
- Contagious Diseases Oxygen Care
- Would you perform:** Errands Empty Bedside Commodes Escort to Appointments
- Bath Meal Preparation Light Housekeeping

Licenses & Certifications

| | License Number | Date Received and/or Expiration Date |
|------------------------------------|----------------|--------------------------------------|
| Certified Nurses Aide (CNA) | | |
| Licensed Practical Nurse (LPN) | | |
| Emergency Medical Technician (EMT) | | |
| Medical Technician Level I | | |
| Personal Care Attendant (PCA) | | |
| Registered Nurse (RN) | | |

Education

| | Name of School Attended | Course of Studies / Degree | Did you Graduate? |
|---------------------------|-------------------------|----------------------------|--|
| High School | | | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Community College | | | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Technical Training School | | | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| College | | | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please list any additional information (including any special skills or equipment) that may be helpful to us in considering your application, for example, if you have experience with a Hoyer Lift.

Do you speak any languages other than English? If so, please circle SPANISH FRENCH Other: _____

Employment History

Please list your last 5 years of employment as related to caregiving or the medical field. If necessary, attach a blank sheet of paper.

Please begin with your current or most recent position.

Most Recent Position – All information must be complete

Employer: _____

Dates of Employment: From: ____ / ____ / ____ to ____ / ____ / ____ **Supervisor: _____

Address _____

**Phone _____ Hourly Rate/Salary Starting: _____ Ending: _____

**Job Title _____

**Reason for leaving _____

**Work Performed/Duties

Second Most Recent Position

Employer: _____

Dates of Employment: From: ____ / ____ / ____ to ____ / ____ / ____ **Supervisor: _____

*Address _____

*Phone _____ Hourly Rate/Salary Starting: _____ Ending: _____

*Job Title _____

**Reason for leaving _____

**Work Performed/Duties

Third Most Recent Position

Employer: _____

Dates of Employment: From: ____ / ____ / ____ to ____ / ____ / ____ Supervisor: _____

Address _____

Phone _____ Hourly Rate/Salary Starting: _____ Ending: _____

Job Title _____

Reason for leaving _____

Work Performed/Duties

Fourth Most Recent Position

Employer: _____

Dates of Employment: From: ____ / ____ / ____ to ____ / ____ / ____ Supervisor: _____

Address _____

Phone _____ Hourly Rate/Salary Starting: _____ Ending: _____

Job Title _____

Reason for leaving _____

Work Performed/Duties

Please be sure you have listed your last 5 years of employment. If necessary, attach a blank sheet of paper.

I certify that all information given herein is true and correct to the best of my knowledge. I authorize any investigation of all statements and information contained in this application for referral which is necessary in arriving at a placement decision.
DNFC, Inc. reserves the right to refuse any applicant for placement.

Signature of applicant

Date:



The applicant listed below has applied for placement through Dependable In Home Care. We would appreciate your answers to the question listed below. All references are kept confidential.

Requested by: Dependable In Home Care Fax number (504) 482-6988 Date: _____

Name: _____ Last 4 digits of Soc Sec #: _____

"I, the undersigned, authorize you to release any information pertaining to my work, skills, experience, or records to Dependable In Home Care."

Applicant Signature: _____

=====
*****APPLICANTS: DO NOT COMPLETE BEYOND THIS POINT*****

Company/Client Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Dates of Employment: ___/___/___ to ___/___/___

Position Held: _____

Job Responsibilities: _____

Was this employee terminated: Yes No If yes, please indicate date: _____

Is individual eligible for rehire: Yes No If no, why: _____

Please rate each of the following characteristics:

Work Quality: excellent good fair poor unacceptable

Cooperative Initiative: excellent good fair poor unacceptable

Attention: excellent good fair poor unacceptable

Interaction with co-workers: excellent good fair poor unacceptable

Interaction with supervisors: excellent good fair poor unacceptable

Additional comments:

Signature

Title

Date

Thank you for your prompt response