Buffalo HomeCare

403 Main St, Suite 520
Buffalo, NY 14203
(716) 322-2780

Application Packet

Name: _____

Training: PCA / HHA

Date: _____

UPDATED 11/14/19

Equal Employment Opportunity Form

This form is a requirement of the U.S. Equal Employment Opportunity Commission, this information is for statistical purposes only and has no bearing on your employment at Buffalo Homecare Inc.

Name: _____

Position applied for: _____

Please indicate the ethnic group (s) with which you identify most: **Place an X**

AMERICAN INDIAN or ALASKAN NATIVE	
ASIAN or PACIFIC ISLANDER	
BLACK or AFRICAN AMERICAN	
HISPANIC or LATINO	
NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER	
TWO or MORE RACES	
WHITE	

Veteran _____ Yes _____ No

Disabled Veteran _____ Yes _____ No

Buffalo Homecare Inc.
Application for Employment

NAME: _____ SOCIAL SECURITY # _____ DATE _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ CELL PHONE: _____ REFERRED BY: _____

POSITION DESIRED: _____ DATE YOU CAN START: _____

Are you employed now? _____ yes _____ no If so, may we contact your current employer? _____ yes _____ no

Ever applied to this company? ____ yes ____no When? _____

EDUCATION:	Name & Address of School	Years Attended	Did you Graduate?	Degree Obtained
High School				
College				
Nursing School				
Special Training				

FORMER EMPLOYERS - LIST LAST 4 EMPLOYERS STARTING WITH THE MOST RECENT

Dates	Name & Address	Phone	Position	Reason for Leaving
From: To:				
From: To:				
From: To:				
From: To:				

PERSONAL REFERENCES (PLEASE PROVIDE TWO REFERENCES (NOT FAMILY)

Name	Address	Phone Number	Years Known

Buffalo HomeCare Inc.

Do you have access to a car if required for work purposes? _____ YES _____ NO

How did you hear about Buffalo HomeCare? _____

Are you legally eligible to be employed in the United States? (Proof of identity and eligibility will be required upon employment): _____YES _____NO

Are you at least 18 years or older? (You must be 18 or older to be employed at Buffalo HomeCare): _____YES _____NO

Have you been convicted of a crime: _____YES _____NO, If Yes, please explain _____

EMPLOYMENT DESIRED: Put an X where you are available to work.

MON. _____	Days _____	Evenings _____
TUES. _____	Days _____	Evenings _____
WED. _____	Days _____	Evenings _____
THURS. _____	Days _____	Evenings _____
FRI. _____	Days _____	Evenings _____
SAT. _____	Days _____	Evenings _____
SUN. _____	Days _____	Evenings _____

AUTHORIZATION:

I understand that if I am being interviewed only, I am not being offered employment at this time. The facts set forth by me in this application are true to the best of my knowledge and belief. I hereby authorize my former employers to give any information regarding my employment with them, and in addition, to furnish any other information they may have concerning me.
I understand misrepresentation or omission of facts on this application is cause for dismissal.
I understand that nothing in this application, in Buffalo HomeCare's statements, policies or procedures, or in my communications with any Buffalo HomeCare official is intended to create an employment contract between Buffalo HomeCare and me. No promises regarding employment have been made to me, and I understand that no such promise or guarantee is binding upon Buffalo HomeCare unless it is made in writing and signed by a company officer. I understand that if an employment relationship is established, I have a right to terminate my employment at any time. I also understand that Buffalo HomeCare retains the right to terminate my employment at any time, with or without notice and with or without cause.
This waiver does not permit the release of disability-related or medical information in a manner prohibited by the release of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant Federal and State laws.

SIGNATURE: _____ DATE: _____

APPLICATION UPDATED 11/14/2019

Conditional Offer of Employment

I understand that Buffalo HomeCare has made me a conditional offer of employment. This offer is contingent upon my complying with the following selection criteria that remain:

- Submission of a health assessment
- Completing all hiring documentation
- Completing orientation

Under certain circumstances, I may be required to meet other screening requirements mandated by law or Buffalo HomeCare policy.

_____
Employee Signature

_____
Employee Printed Name

_____
Date

_____

I extended a conditional job offer to _____ via telephone by reading the above language to him/her.

_____
Buffalo HomeCare Representative

_____
Date

DOH CHRC 103 (10/07)

NYS DEPARTMENT OF HEALTH
Criminal History Record Check Request
Type all information
USE CAPITAL LETTERS

SECTION 1 - SUBJECT INDIVIDUAL

Social Security #

Date of Birth mm/dd/yyyy

LAST Name

FIRST Name

M. I.

Maiden Name

Alias (AKA)

Street Number

Apt. #

Street Name

City

State

Zip

Home Phone

Cell Phone

Birth Country/Place

Use **USA** for United States of America

Sex

Race

Height (ft.-inch)

Weight (lbs.)

Hair

Eyes

SECTION 2 - AGENCY IDENTIFICATION

___ Nursing Home ___ CHHA ___ LTHHCP PFI#

OR ___ LHCSA LICENSE # **2705L001**

Full name of the Agency where applicant will be working

BUFFALO HOMECARE

Authorized Person Last Name

DIETZ

First Name

CARRIE LYNN

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 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 AP:

Date:

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

DOH CHRC form 102: Acknowledgement and Consent for Fingerprinting and Disclosure of Criminal History Record Information

NYS Department of Health, Criminal History Record Check 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	Middle Initial	Maiden Name

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

Mailing Address (street)	City	State	ZIP Code

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. In accordance with applicable laws, DOH will furnish appropriate summary information 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, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. 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. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
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. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for any non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.

NYS Division of Criminal Justice Services Criminal History Bureau Record Review Unit-5th Floor 4 Tower Place Albany, NY 12203 (518) 485-7675	Federal Bureau of Investigation Criminal Justice Information Services (CJIS) Division 1000 Custer Hollow Road Clarksburg, WV 26306

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 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 re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. 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.

Applicant Signature: _____ Date: ____/____/_____

Name and Signature of Parent or Legal Guardian: _____ Date: ____/____/_____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: BUFFALO HOMECARE INC.	Operating License Number (PFI): 2705L001
Print Name of Authorized Person: CARRIE LYNN DIETZ	Title: DIRECTOR OF OPERATIONS
Signature of Authorized Person:	Date:

This form is to be retained by the agency. Do not forward to the DOH CHRC Unit.

07/2016

EMPLOYMENT/CHARACTER REFERENCE REQUEST FORM

Please complete the top portion of the Reference request Form and send it to the reference indicated on the form. Once completed, the reference must mail or fax the form to the address at the bottom of the form.

Applicant's Name: _____ **Date:** _____
(PLEASE PRINT)

Position Applied For: _____ **Soc/Sec #:** _____

I authorize Buffalo HomeCare to request and secure a full and candid reference from the reference named below to provide answers to the questions noted on this form concerning my employment history or character.

Type of Reference: ☐ Work ☐ Character

Company: _____ **Address:** _____

Company Phone#: _____ **Supervisor:** _____

Applicant Signature: _____ **Date:** _____

Dates of Employment: From: _____ **To:** _____ **Would you rehire?** ☐ **Yes** ☐ **No**

Applicant's former/current position held: _____

Reason for Leaving: _____

Character (Employment & Character)	**Exceptional**	**Good**	**Fair**	**Poor**	**Unknown**
Honesty	☐	☐	☐	☐	☐
Integrity	☐	☐	☐	☐	☐
Response to feedback	☐	☐	☐	☐	☐
Trustworthiness	☐	☐	☐	☐	☐
Work Ethic	☐	☐	☐	☐	☐
Service (Employment & Character)	**Exceptional**	**Good**	**Fair**	**Poor**	**Unknown**
Service to others	☐	☐	☐	☐	☐
Ability to help others	☐	☐	☐	☐	☐
Initiative	☐	☐	☐	☐	☐
Dependability	☐	☐	☐	☐	☐
Attendance	☐	☐	☐	☐	☐

Other general comments: _____

_____

Reference Signature: _____ **Date:** _____

Associate Checking Reference: _____ **Date:** _____

Mail completed forms to:
Buffalo Homecare, HR Generalist
403 Main St, Suite 520
Buffalo, NY 14203
(P) 716-322-2780
(F) 716-322-2778

EMPLOYMENT/CHARACTER REFERENCE REQUEST FORM

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Response to feedback	☐	☐	☐	☐	☐
Trustworthiness	☐	☐	☐	☐	☐
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Ability to help others	☐	☐	☐	☐	☐
Initiative	☐	☐	☐	☐	☐
Dependability	☐	☐	☐	☐	☐
Attendance	☐	☐	☐	☐	☐

Other general comments: _____

_____

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Buffalo HomeCare

Pre-Employment Physical

Employee Print Name: _____ Signature: _____
Sex: ( ) M ( ) F

Tuberculosis test Performed Date:_____ Date Read_____ Results_____
Chest X-ray: Negative ( ) Positive ( ) Date Read_____ Results_____
Rubella: Immune ( ) Non-Immune ( ) Titre Level Please provide Lab Report
Rubeola: Immune ( ) Non-Immune ( ) Titre Level Please provide Lab Report

PHYSICAL EXAM

VITAL SIGNS: BP _____ PULSE_____ RESPIRATION_____

SYSTEMS REVIEW:	Normal	Abnormal		Normal	Abnormal
Skin	_____	_____	Extremities/Joints	_____	_____
Head-Neck	_____	_____	Neurologic	_____	_____
Eyes	_____	_____	Gait	_____	_____
Ears	_____	_____	Thyroid	_____	_____
Nose	_____	_____	Spinal Column	_____	_____
Throat-Mouth	_____	_____	Heart	_____	_____
G.U.	_____	_____	Abdomen	_____	_____

Details of Abnormal Findings: _____

_____

_____

Does the employee have any physical or mental limitations that would interfere with his/her ability to perform and complete his/her job as described in the attached job description? Yes ( ) No ( )
If yes, explain: _____

Does the employee who is identified to be at risk of occupational exposure have any medical problems that would interfere with his/her job to use protective clothing and equipment (ex. Gloves, Masks, Gowns, etc.)?
Yes ( ) No ( ) If yes, explain: _____

After completion of the evaluation, my recommendation is:

( ) Acceptable for work without restrictions
( ) Acceptable for work with restrictions (ex. Lifting)
Explain: _____
( ) Not acceptable for work.
Explain: _____

The individual evaluated appears to be free from Tuberculosis and/or other communicable, contagious, or infectious disease and is capable of performing the duties as outlined above. The individual examined has been informed of the results of the examination and/or medical conditions which may require further examination or treatment and it is his/her responsibility to seek further medical care. He/she appears to be free of any impairment which might interfere with the performance of duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter behavior.

_____ _____ _____
Professional Signature License # Date

_____ _____
Address Phone Number

Pre-Employment Physical

EMPLOYEE PRINT NAME: _____

EMPLOYEE PERSONAL HEALTH HISTORY

Have you had any of the following?

	YES	NO		YES	NO
Tuberculosis			**Substance Addiction**		
Heart Disease			**Ulcers**		
Diabetes			**Epilepsy**		
Chest Pain			**Back Pain**		
Shortness of breath			**Allergies**		
Asthma			**Kidney Disease**		
Heart murmurs			**Hernia**		
High Blood Pressure			**Dizziness**		
Chronic, productive cough			**Hearing Loss**		
Frequent, severe headaches			**Vision Loss**		

Explain any "yes" answers: _____

_____

_____

Other: _____

I hereby authorize the release of my health information to Buffalo HomeCare. If I should develop symptoms during my employment which may indicate a communicable, contagious or infectious illness, or if I suffer a work-related injury, I will immediately notify my Supervisor at Buffalo HomeCare.

To the best of my knowledge, the foregoing is correct and complete, and may be sued to whatever extent necessary in connection with my application for employment at Buffalo HomeCare. **I further understand that falsification of this information is grounds for dismissal.**

_____ // _____ // _____

Signature Date Social Security Number

PHYSICIAN STATEMENT

Notice of Importance:

Our medical facilities require a physician's statement of good health. This form must be filled out completely with the appropriate physician signature and information included. We must receive this completed statement before you begin employment, however do not delay in sending your completed application while getting this form completed.

We will accept an alternate physician statement, but only if all the following information is included. Please remember to attach all copies of test results.

I hereby authorize the undersigned physician to release any medical information relevant to employment to Buffalo Homecare.

_____ _____

Print Employee Name Date of Examination

_____ _____

Employee Signature Date

I certify that I have performed a physical examination on the above mentioned individual and I further certify that this patient is in good physical and mental health, and he/she appears to be free of any impairment which might interfere with the performance of duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter behavior which would restrict him/her from providing services as a Registered Nurse, Licensed Practical Nurse, Home Health Aide or Personal Care Aide.

_____ _____

Physician's name Date

_____

Physician's Signature

Physician Office Information or Stamp:

BUFFALO HOMECARE INC

STATEMENT OF GOOD HEALTH/FREE OF COMMUNICABLE

PPD CONSENT FORM

Explanation and Instruction:
Our company policy requires all employees who have direct contact with patients in the home setting to submit a statement from an appropriately licensed health care professional, based on an exam performed within the last twelve months. The employee must show no apparent signs or symptoms of communicable disease.

Statement to be signed by a Physician or appropriately licensed Healthcare professional.

Employee's Name (print): _____ Date: _____

Employee's Signature: _____ Social Security #: _____

_____was examined by me on _____. He/She is in adequate health to perform home health duties and show no apparent signs or symptoms of communicable disease.

_____ _____ _____
Professional Name/Title **Signature** **Date**

_____
Address **City** **State** **Zip Code** **Phone Number**

A PPD test was done in this office on _____ by_____.
Date Professional Name/Title

and read on _____ by_____.
Date Professional Name/Title

Site: ____ Right Forearm ____ Left Forearm Testing Solution: ____ Tubersol ____ Aplisol

Manufacturer:_____ Lot number:_____ Exp. Date: _____

PPD Result:_____ If redness present; size/description_____.

Follow-up recommendation for a Positive Reaction: _____.

FLU VACCINATION FORM

Buffalo Homecare recommends that you receive the Influenza Vaccination based on the following information from the Centers for Disease Control and Prevention's (CDC):

- Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.
- Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.
- Flu vaccine can keep you from getting flu, make flu less severe if you do get it, and keep you from spreading flu to your family and other people.
- A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.
- There is no live flu virus in flu shots. **They cannot cause the flu.**
- There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.
- CDC, the Advisory Committee on Immunization Practices (ACIP), and the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommend that all U.S. health care workers get vaccinated annually against influenza.
- Influenza (the flu) can be a serious disease that can lead to hospitalization and sometimes even death. Anyone can get very sick from the flu, including people who are otherwise healthy.
- You can get the flu from patients and coworkers who are sick with the flu. If you get the flu, you can spread it to others even if you don't feel sick.
- By getting vaccinated, you help protect yourself, your family at home, and your patients.

Buffalo Homecare is strongly encouraging you to get the Flu Vaccination; we are making the influenza vaccination available to you free of charge. You are free to decline for any reason (or no reason at all) and may reconsider your decision in the future. **** **<u>If you are declining the vaccination, you must complete the statement below.</u>**

By signing below:

1. I attest that I have read the above facts and the attached Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement in their entirety and fully understand them;
2. Despite this information, I am declining he influenza vaccination: (select one of the following)

☐ I have already received the influenza vaccination since this past July 1st and am providing a receipt from the individual/entity who administered the vaccination (NOTE: The receipt must include date, name and business address).

☐ I have not received the influenza vaccination (or cannot provide proof of having received it). **As such, *I am required to wear a Buffalo HomeCare facial mask when working in areas where patients may be present during the influenza season.*** This requirement applies regardless of the reason why I am unvaccinated.

3. I agree to indemnify and hold harmless Buffalo HomeCare and its directors, officers, employees, volunteers, representatives, agents, sponsors and affiliates from any and all claims arising from my consent or refusal to accept the influenza vaccination.

_____
Name

_____
Signature

_____
Date

For use if Reconsideration

☐ I originally declined the influenza vaccination; however, I have since been vaccinated and all required information is attached.