UHS Unique Homecare Services
Together We Can.™

Unique HomeCare Services
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auniquehomecareservices.com

Employment Application

Please Print Clearly

PERSONAL INFORMATION			
LAST NAME:	FIRST NAME:	MIDDLE NAME:	DATE:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	EMAIL ADDRESS:	
☐ MALE ☐ FEMALE	ARE YOU OVER 18: ☐ YES ☐ NO	DO YOU HAVE A DRIVER'S LICENSE: ☐ YES ☐ NO	
EMPLOYMENT DESIRED: ☐ PART-TIME ONLY ☐ PART-TIME OR FULL-TIME ☐ FULL-TIME ONLY			
ARE YOU AVAILABLE TO WORK WEEKENDS: ☐ YES ☐ NO		ARE YOU AVAILABLE TO WORK NIGHTS: ☐ YES ☐ NO	
WHAT IS YOUR IDEAL NUMBER OF HOURS PER WEEK?		WHEN ARE YOU AVAILABLE TO START?	

HOURS AVAILABLE TO WORK						
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

HOW DID YOU HEAR ABOUT UNIQUE HOMECARE SERVICES?	
DO YOU HAVE ANY FAMILY OR FRIENDS WORKING FOR UNIQUE HOMECARE SERVICES? ☐ YES ☐ NO	
IF YES, PLEASE STATE THEIR NAME AND RELATIONSHIP:	
NAME:	RELATIONSHIP:
NAME:	RELATIONSHIP:

EDUCATION				
TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION	YEARS COMPLETED	DEGREE
HIGH SCHOOL				
COLLEGE				
PROFESSIONAL				

EMPLOYMENT HISTORY

1. NAME AND ADDRESS OF CURRENT/LAST EMPLOYER	SUPERVISOR'S NAME	EMPLOYMENT DATES	PAY OR SALARY
		FROM: TO:	START: FINAL:

PHONE NUMBER	YOUR JOB TITLE

LIST THE DUTIES YOU PREFORMED WHILE WORKING FOR THIS EMPLOYER
THE REASON FOR LEAVING THIS EMPLOYER? PLEASE BE SPECIFIC
MAY WE CONTACT THIS EMPLOYER? □ YES □ NO
IF NO, PLEASE EXPLAIN WHY?

2. NAME AND ADDRESS OF PAST EMPLOYER	SUPERVISOR'S NAME	EMPLOYMENT DATES	PAY OR SALARY
		FROM: TO:	START: FINAL:

PHONE NUMBER	YOUR JOB TITLE

LIST THE DUTIES YOU PREFORMED WHILE WORKING FOR THIS EMPLOYER
THE REASON FOR LEAVING THIS EMPLOYER? PLEASE BE SPECIFIC
MAY WE CONTACT THIS EMPLOYER? □ YES □ NO
IF NO, PLEASE EXPLAIN WHY?

2. NAME AND ADDRESS OF PAST EMPLOYER	SUPERVISOR'S NAME	EMPLOYMENT DATES	PAY OR SALARY
		FROM: TO:	START: FINAL:

PHONE NUMBER	YOUR JOB TITLE
LIST THE DUTIES YOU PREFORMED WHILE WORKING FOR THIS EMPLOYER	
THE REASON FOR LEAVING THIS EMPLOYER? PLEASE BE SPECIFIC	
MAY WE CONTACT THIS EMPLOYER? ☐ YES ☐ NO	
IF NO, PLEASE EXPLAIN WHY?	

SKILLS

HOW WOULD YOUR RATE YOURSELF ON YOUR EXPERIENCE WITH THE FOLLOWING ASPECTS OF CAREGIVING?

1 = NO EXPERIENCE 2 = SOME EXPERIENCE 3 = GOOD EXPERIENCE 4 = EXCELLENT EXPERIENCE

DEMENTIA / ALZHEIMER'S CARE	☐ 1	☐ 2	☐ 3	☐ 4
INCONTINENCE CARE	☐ 1	☐ 2	☐ 3	☐ 4
DRESSING/ GROOMING	☐ 1	☐ 2	☐ 3	☐ 4
BATHING/SHOWERING	☐ 1	☐ 2	☐ 3	☐ 4
TRANSFERRING	☐ 1	☐ 2	☐ 3	☐ 4
LIGHT HOUSEKEEPING	☐ 1	☐ 2	☐ 3	☐ 4
MEAL PREPARATION	☐ 1	☐ 2	☐ 3	☐ 4

AN APPLICATION FORM SOMETIMES MAKES IT DIFFICULT TO SUMMARIZE YOUR COMPLETE BACKGROUND. USE THE SPACE BELOW TO ADD ANY ADDITIONAL INFORMATION TO DESCRIBE YOUR FULL QUALIFICATIONS TO BE A CAREGIVER.

WHY DO YOU ENJOY CAREGIVING?

PERSONAL REFERENCES

PLEASE DO NOT USE RELATIVES OR PREVIOUS SUPERVISORS	
1. NAME	RELATIONSHIP
PHONE NUMBER	YEARS KNOW
2. NAME	RELATIONSHIP
PHONE NUMBER	YEARS KNOW

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENSE (FELONY OR SERIOUS MISDEMEANOR)? □ YES □ NO (CONVICTIONS FOR MARIJUANA RELATED OFFENSES THAT ARE MORE THAN TWO YEARS OLD NEED NOT BE LISTED.
IF YES, STATE THE NATURE OF THE CRIME(S), WHEN ARE WHERE, AND THE DISPOSITION OF THE CASE.
ARE YOU NOW, OR HAVE YOU EVER BEEN UNDER INVESTIGATION, SUSPENSION OR EXCLUDED FROM PARTICIPATION IN THE MEDICARE/MEDICAID PROGRAMS OR OTHER STATE/OR FEDERAL PROGRAMS? □ YES □ NO
IF YES, STATE THE NATURE OF THE INCIDENT, WHEN ARE WHERE INCIDENT TOOK PLACE, AND THE OUTCOME

PLEASE READ EACH PARAGRAPH AND SIGN BELOW.

I hereby certify, under penalty of perjury, that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge.

I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

I understand that it is my responsibility to notify the Agency in writing if an investigation begins or if I become suspended or excluded from participation in the Medicare/Medicaid Programs or other state/federal programs.

I hereby authorize the Agency to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the references I have listed to disclose to the Agency any and all letters, reports and other information related to my work records. In addition, I hereby release the company, my former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure.

I understand that any offer of employment regarding certain job positions may be conditioned upon satisfactory completion of a background check, medical examination and/or a drug and alcohol screen. I agree to sign a release of medical information authorization form and to submit to a medical examination and/or drug and alcohol screen should the Agency condition my offer of employment upon successful completion of such an examination or screening.

I acknowledge that I have read all of the above statements and that I understand them. In addition, the statements above supersede and replace any prior understandings or discussions I have had with the Agency and set forth the complete agreement between me and the Agency regarding these matters.

APPLICANT'S SIGNATURE DATE