Uniform Employment
Application for Nurse Aide Staff

This application form is required by Title 63 O.S. Section 1-1950.4 of state law and by the Oklahoma State Board of Health Rules OAC 310-2-15-3. This uniform application shall be used as the only application for employment of nurse aides in nursing and specialized nursing facilities, residential care homes, assisted living centers, continuum of care facilities, hospice programs, adult day care centers and home care agencies on and after January 1, 2001.

This employer does not discriminate in its hiring decisions or in any other employment decision on the basis of race, color, sex, religion, citizenship, national origin, veteran status, age or upon a physical or mental disability which is unrelated to the applicant's/employee's ability to perform the essential functions of the position.

Date of Application _____ Date Available to Start Work _____

Personal Information

Name: _____ Social Security Number _____
(Last) (First) (Middle)

List any other name(s) you have worked under: _____

Present address: _____
(Street) (City) (State) (Zip)

Permanent Address (if different than present address): _____
(Street) (City) (State) (Zip)

Phone Number: _____ Emergency Contact Person: _____
(Name) (Address) (Phone Number)

Employment Desired

Position applied for: _____ Salary required: _____

Hours available to work: _____ Days _____ Evenings _____ Nights _____ Weekends

Will you accept employment of: _____ Full Time? _____ Part Time? _____ Occasional Part Time?

U.S. Military Record

Branch: _____ Date Entered: _____ Date and Type of Discharge: _____

Prior Work History (List your last four (4) jobs beginning with your most recent or current employer.)

Employer's Name and Address: _____

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year)_____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

Employer's Name and Address: _____

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year)_____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

Prior Work History (Continued)

Employer's Name and Address: _____

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year)_____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

Employer's Name and Address: _____

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year)_____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

List name(s) of all other employers for the last five (5) years:

_____

_____

_____

May we contact your present employer? _____ Yes _____ No _____ Not applicable

Have you ever been terminated or asked to resign from any position? _____ Yes _____ No

Educational Background (List all educational schools attended with degrees, diplomas or certificates received.)

Name of Institution (High School, Technical School, College)	Type of Studies	Dates Attended & Diplomas, etc.

If your school or employment records are under another name(s), indicate that name(s): _____

Certification

If you hold a current certification as a nurse aide (CNA), check the appropriate certification(s) below:

____ Long Term Care (LTC) ____ Home Health Aide (HHA) ____ Adult Day Care (ADC)

____ Residential Care Aide (RCA) ____ Developmental Disability Aide (DDA) ____ Certified Medication Aide (CMA)

List all technical special skills or education honors, certificates, licenses, memberships or Medication Administration Technician (MAT) certification not previously listed: _____

_____

If you are a CMA, have you obtained your 8 hours of continuing education for this calendar year? _____ Yes _____ No

References (List name, address and telephone number of three references who are not relatives or former employees.)

Background Information

If you answer YES to any of the questions below, explain in the space after the questions. The explanation for a YES answer should include, but no be limited to:

1. State and/or jurisdiction
2. Nature of complaint
3. Disposition of complaint; e.g., "dismissed insufficient evidence"
4. Date of disposition
5. Copies of any correspondence received by applicant with regard to the complaint.

1. _____ Yes _____ No Have you ever been arrested, charged with, entered a plea of guilty, no contest, convicted of or been sentenced for any criminal offence in any state of US jurisdiction?

2. _____ Yes _____ No Have you ever been found to have violated any state, US jurisdiction or federal law regulating the practice of a health care profession?

3. _____ Yes _____ No Are any disciplinary actions pending against your CNA certificate or health care professional license in any state of US Jurisdiction?

4. _____ Yes _____ No Have you had any certificate, license, registration or other privilege to practice a health care profession denied, revoked, suspended, restricted, reprimanded, censured or placed on probation by a state or US jurisdiction, federal or foreign authority or have you ever surrendered such credential to avoid or in connection with action by such authority?

Applicant's Certification and Agreement

(PLEASE READ CAREFULLY – If you answer NO to any of the questions below, explain in the space after the question.)

1. _____ Yes _____ No I understand that the employer has the right to proceed with any criminal background check.

Applicant's Certification and Agreement (Continued)

(PLEASE READ CAREFULLY - If you answer NO to any of the questions below, explain in the space after the question.)

2 _____ Yes _____ No I understand that as a part of the job selection process, I may be required to take a drug-screening test at the time of employment and if requested in accordance with the state and federal law at anytime during my employment. A test result that has been confirmed as positive will eliminate me from employment. If I refuse to sign this form and submit to drug testing the employer will reject my application.

3 _____ Yes _____ No I understand that I may required to have a physical examination and I hereby consent to take a physical examination and any future examinations as required by the employer.

4 _____ Yes _____ No I understand that if I am hired I will be required to produce proof that I have a legal right to work in the U.S.A. in accordance with the IRCA of 1986.

5 _____ Yes _____ No I understand that this form is not an employment contract.

I certify that the information provided on this application is true and complete and I understand that false information or omission of facts may disqualify me from employment and may cause termination if discovered at a later date.

Signature of Applicant

Date of Signature

Oklahoma State Department of Health • Nurse Aide Registry Tracking Form

1000 N.E. 10th Street • Oklahoma City, OK 73117-1299 • Telephone: (405) 271-4085

Submit this form to the Nurse Aide Registry, within 30 days of applicant's employment start date.

Personal Information

Name: _____
(Last) (First) (Middle) (Maiden or Any Other)

Address: _____ Social Security Number: _____
(Street or P.O. Box) (City) (State) (Zip)

Date of Birth: _____ Sex: ____ M ____ F Race: _____ Daytime Phone Number: _____

Previous CNA Training – Complete this section only if you will require training at this place of employment

If you have had CNA Training in the past for any of the categories of LTC, HHA, ADA, RCA or DDA, please fill out the following:

Category: _____ Employer Name: _____ Number of Training Days: _____
Category: _____ Employer Name: _____ Number of Training Days: _____
Category: _____ Employer Name: _____ Number of Training Days: _____

Criminal Arrect Check List

Employment at this employer shall not be considered if the below signed individual has been convicted of one of the following crimes as stated by Oklahoma Statute, Section 1-1950.1 (F) (1) Title 63 (A through P of the list in this section):

A. Assault, battery or assault and battery with a dangerous weapon
B. Aggravated assault and battery
C. Murder or attempted murder
D. Manslaughter except involuntary manslaughter
E. Rape, incest or sodomy
F. Indecent exposure and indecent exhibition
G. Pandering
H. Child Abuse
I. Abuse, neglect or financial exploitation of any person entrusted to his care or possession
J. Burglary in the first or second degree
K. Robbery in the first or second degree
L. Robbery or attempted robbery with a dangerous weapon, or imitation firearm
M. Arson in the first or second degree
N. Unlawful possession or distribution, or intent to distribute unlawfully, Schedule I through V drugs as defined by the Uniform Controlled Dangerous Substance Act.
O. Grand larceny, or
P. Petit larceny or shoplifting within the past seven (7) years

It is further understood that if I am hired, it will be as a temporary employee until my criminal background check is received by the employer. If I have no criminal record in accordance with state law, I may be considered for employment, subject to training requirements and other requirements of the job for which I am applying with this employer.

I hereby certify that I have no previous convictions as listed in the Oklahoma Statute, Section 1-1950.1 (F) (1) Title 63 (A though P of the list in this section). My signature below authorizes the employer to run a check with the Nurse Aide Registry of the Oklahoma State Department of Health for notations of abuse, neglect or misappropriation of resident's property. I hereby give the Oklahoma State Department of Health and the Oklahoma State Bureau of Investigations authority to proceed with criminal record history checks as required by law.

_____ _____
Signature of Applicant Date of Signature

This section to be completed by the employer. Please do not detach this section, submit the whole page to the department.

Employer/Applicant Information

Employment Start Date: _____

The applicant is:
☐ A Certified Nurse Aide in the state of Oklahoma
☐ Providing services as a Personal Care Assistant in a Medicaid-certified home health agency
☐ Enrolled in a training program – Training Start Date: _____
(The training date must be supplied unless applicant is certified or a PCA)

Employer Name: _____ Employer Type: _____

Employer Address: _____ Phone Number: _____

Loving Care
In-Home Health and Hospice Services

Authorization to Release Information

Loving Care In-Home Health and Hospice Services
312 Cherry Street P.O. Box 1414
Noble, OK 73068
405-872-1515

Notification of Criminal Arrest Check

House Bill 2100 requires all licensed nursing facilities to offer only *temporary* employment to licensed and non-licensed personnel until a criminal arrest check can be completed. That bill also provides that a facility shall inform each applicant for employment that the facility is required to obtain such information. Any person found to have a conviction for certain specified crimes cannot be offered permanent employment.

I, _____, hereby authorize any person or entity, public or private, having any information concerning my background, including but not limited to, credit records, criminal law violations, education records, driving record, state tax records, employment records, professional licenses and disciplinary matters to release such information to Loving Care. This information is to be used for possible employment with Loving Care.

I further authorize, intend and understand that this release of information shall continue and remain in full force and effect at all times during my employment with Loving Care and may be used at any time during my employment with Loving Care.

_____ _____ *Male/Female*
Applicant Signature *Date* *(Circle One)*

_____
Print Full Name including Middle Initial

_____ _____
Any other names Used *Social Security Number*

_____ _____
Street Address *Date of Birth*

_____ _____
City, State, Zip Code *Telephone Number*

_____ _____
Drivers License Number *State of Drivers License/Expiration Date*

Loving Care In-Home Health Services
HOME HEALTH HOSPICE PRIVATE DUTY

124 S. Main St., P.O. Box 1414
Noble, Oklahoma 73068
(405) 872-1515

DEAR PROSPECTIVE EMPLOYEE

PLEASE READ

In 2009 the government initiated the American Recovery and Reinvestment Act better known as the Stimulus Package. You are being asked for the following information to determine if you're potential employer will be eligible for certain tax credit benefits for hiring employees that meet specific eligibility requirements.

The company that you are interviewing with may be able to obtain certain valuable tax credits based upon your answers to the questions on the two attached documents. Please take your time and answer the questions carefully, completely, and accurately. This information is requested voluntarily. You are not required to complete this questionnaire; however, the information is required for your potential employer to receive the federal tax credit.

Government Tax Credits have been expanded in recent years. Your answers to these questions will not affect your eligibility for employment or any benefits you or your family may currently be receiving. Your assistance is appreciated.

Sincerely,

Loving Care In-Home Health and Hospice Services

Form **8850** (Rev. August 2009)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

▶ See separate instructions.

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ▶ _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number ( ) -

If you are under age 40, enter your date of birth (month, day, year) / /

1 ☐ Check here if you are completing this form **before** August 28, 2009, and you lived in the area impacted by Hurricane Katrina on August 28, 2005. If so, please enter the address, including county or parish and state where you lived at that time.

2 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

3 ☐ Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  - a Received SNAP benefits (food stamps) for the past 6 months, **or**
  - b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was discharged or released from active duty in the U.S. Armed Forces during the past 5 years **and**, for at least 4 weeks during the past year, I received unemployment compensation.
- I am at least age 16 but **not** age 25 or older, **and**:
  - a During the past 6 months, I have not attended a secondary, technical, or post-secondary school for more than an average of 10 hours per week, not counting periods during which the school was closed for scheduled vacations, **and**
  - b During the past 6 months, if I was employed, during each consecutive 3-month period within the past 6 months, I earned less than I would have earned if I had worked for the applicable minimum wage 30 hours every week during the 3-month period, **and**
  - c I do not have a certificate of graduation from a secondary school or a General Education Development (GED) certificate **or** I have a certificate that was awarded at least 6 months ago and I have not held a job (other than occasionally) or been admitted to a technical or post-secondary school since I received the certificate.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability **and**, during the past year, you were:

- Discharged or released from active duty in the U.S. Armed Forces, **or**
- Unemployed for a period or periods totaling at least 6 months.

5 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months, **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ **Date** / /

00645 Loving Care In-Home Health Services

Paycom

Tax Credit Questionnaire

Paycom will not disclose or use information provided by applicant except in connection with providing the subject services or to the extent otherwise authorized by Client.

Answering the following questions is voluntary and does not affect any benefits you or your family may be receiving or your job opportunity. I hereby authorize the release of any information from any federal or state Government Agency including SSA, Dept. of Veterans Affairs, or DMV of any state as to my eligibility for federal or state tax credit programs.

Signature Required (Sign and Date inside the box)

Print Name: First Last		Social Security Number (last 4 digits only) XXX -- XX –
Street Address		Phone Number
City	State	Zip Code

1. Are you at least age 16, but under age 40? Yes ___ No ___
   If YES, enter your date of birth _____

2. Have you ever worked for this employer before? Yes ___ No ___
   If Yes, enter last date of employment _____

3. Have you been unemployed or have not worked for anyone for more than 40 hours during the past 60-day period? Yes ___ No ___

4. Are you a Veteran of the U.S. Armed Forces? Yes ___ No ___
   If NO, go to Question 5
   If YES, are you a member of a family that received SNAP (Food Stamps) benefits for at least a 3-month period during the past 15 months before you were hired? Yes ___ No ___
   If YES, enter name of *primary recipient* _____ and *city and state* where benefits were received _____.
   OR, are you a veteran entitled to compensation for a service-connected disability? Yes ___ No ___
   If Yes, were you discharged or released from active duty within the year before you were hired? Yes ___ No ___
   OR, were you unemployed for a combined period of at least 6 months during the year before you were hired? Yes ___ No ___

5. Are you a member of a family that received Supplemental Nutritional Assistance Program (SNAP) (Food Stamps) benefits for the 6 months before you were hired? Yes ___ No ___
   OR, received SNAP benefits for at least a 3-month period within the last 5 months **But** you are no longer receiving them? Yes ___ No ___
   If YES to either question, enter name of *primary recipient* _____ and *city and state* where benefits were received _____.

6. Were you referred to an employer by a Vocational Rehabilitation Agency approved by a State? Yes ___ No ___
   OR, by an Employment Network under the Ticket to Work Program? Yes ___ No ___
   OR, by the Department of Veterans Affairs? Yes ___ No ___

7. Are you a member of a family that received TANF assistance for at least the last 18 months before you were hired? Yes ___ No ___
   OR, are you a member of a family that received TANF benefits for **any** 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended within 2 years before you were hired? Yes ___ No ___
   OR, did your family stop being eligible for TANF assistance within 2 years before you were hired because a Federal of state law limited the maximum time those payments could be made? Yes ___ No ___
   If NO, are you a member of a family that received TANF assistance for any 9 months during the 18 month period before you were hired? Yes ___ No ___
   If YES to any question, enter name of *primary recipient* _____ and the *city and state* where benefits were received _____.

8. In the past 12 months, have you had a felony conviction, felony probation, work release, or prison release? Yes ___ No ___
If **YES**, enter *date of conviction* _____ and *date of release* _____.
Was it a Federal _____ or a State _____ conviction? (Check one)

9. Did you receive Supplemental Security Income (SSI) benefits for any month ending within 60 days before you were hired? Yes ___ No ___

10. Are you an unemployed veteran who served on active duty (other than active duty for training) in the Armed Forces of the United States for a period of more than 180 days? Yes ___ No ___
OR, were you discharged or released from active duty in the Armed Forces for a service-connected disability? Yes ___ No ___
If YES, were you discharged or released from active duty in the Armed Forces at any time during the 5-year period ending on the hiring date? Yes ___ No ___
If YES, did you receive unemployment compensation for not less than four weeks during the one-year period ending on your hiring date? Yes ___ No ___

11. Are you at least 16 but under age 25? Yes ___ No ___
If YES, did you not regularly attend any secondary, technical, or post-secondary school during the 6-month period before your hiring date? Yes ___ No ___
If YES, were you not regularly employed during that 6-month period? Yes ___ No ___
If YES, were you not employable because you lacked basic skills? Yes ___ No ___

12. If you lived in the area impacted by Hurricane Katrina on August 28, 2005, please enter the address, including county or parish and state where you lived at that time.

_____
Street Address

_____
City, State, Zip

_____
County or Parish

Employer use only

Please send both pages of this Questionnaire, both pages of the 8850 (all with original signatures), supporting documentation to:
Paycom, ATTN: Tax Credit Dept.
7510 W Memorial Rd, MS # 150
Oklahoma City, OK 73142

This documentation is time sensitive and must be received by Paycom no later than 21 days from the new employee's start date to allow Paycom to time to review and submit the new employee's package to the State Workforce Agency. Request for certification does not guarantee approval.

Starting Wage $_____

Position Title _____

Hire Date _____

Start Date _____