



Thank you for your interest in employment with Great Lakes Home Healthcare Services!

Instructions

Please refer to the packet of information that was prepared for you and complete the following:

- Application Reference Release Two References Requests*

For clinical positions:

- for Home Health Aide positions: Home Health Aide Assessment Sheet for LPN/RN positions: LPN/RN Assessment Sheet

A Notice of Summary of Your Rights under the Fair Credit Reporting Act has been included for your information.

We are also required to gather additional information from you to be considered for employment:

- A copy of your high school diploma / GED or college degree
- For Home Health Aide positions: A copy of your certificate documenting completion of a Nurse Assistant training program or copy of state certification
- For Nursing positions: A copy of your PA and/or NY State Nursing License
- For positions requiring licensure: A copy of your PA and/or NY license

***IMPORTANT:** You will also be given 2 (two) reference forms to be completed by your last 2 employers indicating your previous supervisors' name and contact information (including US Military Service). If you are a student or have limited work experience, have 3 (three) references (non-family or friends) such as instructors, pastor, or other professional complete.

Please note: References will be verified.

Thank you again for your interest in employment with Great Lakes Home Healthcare Services. If you have any questions regarding this information, please contact us at 814-877-6121 and ask to be connected to Human Resources.



1700 Peach Street
Erie, PA 16501
(814) 877-6121

EMPLOYMENT APPLICATION

PLEASE READ CAREFULLY: Delays in processing this application may result if both sides are not completed in full. This organization is an **equal opportunity employer** which does not discriminate in employment practices based on race, color, religion, sex, age, disability, non-job related handicap, marital or veteran status, national origin or any other characteristic protected by law; nor is any question on this application asked for the purposes of limiting or excluding any applicant's consideration for employment for these reasons.

Position Applied For: _____

PERSONAL				
LEGAL NAME: Last	First	Middle	Social Security Number	
ADDRESS: Address	City	State	Zip Code	Telephone Number ()
Are you either a U.S. Citizen or an Alien who has the legal right to work in the job for which you are applying? <input type="checkbox"/> YES <input type="checkbox"/> NO		(Documents establishing your identity and authorization for employment in the United States must be presented no later than 72 hours after starting employment.)		
REFERRAL SOURCE: <input type="checkbox"/> Advertisement <input type="checkbox"/> Friend <input type="checkbox"/> Walk-In <input type="checkbox"/> Employment Agency <input type="checkbox"/> Website: <input type="checkbox"/> Employee (Name):			Are you on Layoff and subject to recall? <input type="checkbox"/> YES <input type="checkbox"/> NO	
EDUCATION				
<u>Name of School or Institutions (include high school)</u>		<u>Complete Address</u>		<u>Professional Training or Type of Degree</u>
WORK HISTORY (Give a complete record of all employment) including Military Service. (Complete addresses <i>must</i> be given for mailing references.)				
<u>Last or Present</u>		<u>Date Employed</u>	<u>Salary</u>	<u>Description of Work</u>
Employer: _____ Address: _____ City: _____ ST: _____ Zip: _____ Phone: _____ Supervisor: _____		From: _____ To: _____	\$ _____	
		<u>Job Title</u>	<u>Reason for Leaving</u>	
<u>Previous</u>		<u>Date Employed</u>	<u>Salary</u>	<u>Description of Work</u>
Employer: _____ Address: _____ City: _____ ST: _____ Zip: _____ Phone: _____ Supervisor: _____		From: _____ To: _____	\$ _____	
		<u>Job Title</u>	<u>Reason for Leaving</u>	
<u>Previous</u>		<u>Date Employed</u>	<u>Salary</u>	<u>Description of Work</u>
Employer: _____ Address: _____ City: _____ ST: _____ Zip: _____ Phone: _____ Supervisor: _____		From: _____ To: _____	\$ _____	
		<u>Job Title</u>	<u>Reason for Leaving</u>	
MAY WE CONTACT YOUR PRESENT EMPLOYER FOR A REFERENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Professional License #:	State:	Date Available:	Have you ever been employed with this agency before? <input type="checkbox"/> Yes <input type="checkbox"/> NO If Yes, dates:	

Work Availability: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Per Diem <input type="checkbox"/> Days <input type="checkbox"/> Evenings <input type="checkbox"/> Nights <input type="checkbox"/> Weekends <input type="checkbox"/> Other			
Other Qualifications/Specialized Skills : _____			
Have you ever pleaded guilty to, or been convicted of, any felony or misdemeanor? (Exclude summary offenses) <input type="checkbox"/> NO <input type="checkbox"/> YES (A criminal conviction will not necessarily be a barrier to employment. We will consider the nature of the crime, its job relatedness, subsequent rehabilitation and any other factors in evaluating whether hiring you would promote a security or other risk) NOTE: A criminal history check is mandatory for all perspective employees.			
References (3) Please do not list relatives, previous employers, or persons you have known less than one year.			
Name:	Address:	City/State/Zip:	Phone:
Name:	Address:	City/State/Zip:	Phone:
Name:	Address:	City/State/Zip:	Phone:
EMPLOYMENT IS DEPENDENT UPON SATISFACTORILY PASSING AN EMPLOYMENT PHYSICAL, WHICH INCLUDES A NON- INVASIVE SUBSTANCE ABUSE SCREEN, GIVEN TO ALL EMPLOYEES.			
I hereby certify that the foregoing statements are true and correct to the best of my knowledge and belief and hereby grant Great Lakes Home Healthcare Services permission to verify such answers and investigate work and personal references. I understand that any false statements on this application or in any interview may be considered sufficient cause for rejection of this application or for dismissal if such false information is discovered subsequent to my employment. I also understand that my salary, wages, benefits and other terms or conditions of employment. I also understand that my salary, wages, benefits and other terms or conditions of employment are subject to change by Great Lakes Home Healthcare Services and, if hired, I will be notified of these changes. I hereby agree to take physical and examinations whenever required by Great Lakes Home Healthcare Services. I also understand Great Lakes Home Healthcare Services has established a smoke free environment in many areas of the organization and thereby has banned the use of all smoking materials in these areas by employees while on the premises. I authorize the employers, schools or persons named above to give any information regarding my previous employment, character, general reputation and personal characteristics, together with any information that they have regarding me, whether or not it is in their records. I understand that no representation, whether oral or written, by any representative, agent or supervisor of Great Lakes Home Healthcare Services can constitute a contract of employment of any kind, I further understand that; my employment with GLHHS may be terminated, with or without cause and with or without notice, at any time, at the option of either GLHHS or me. In addition, if accepted for employment, I hereby agree to abide by the rules and regulations of GLHHS and to accept the established pay period of GLHHS.			
SIGNED		DATE	

FOR PERSONNEL USE ONLY: CONFIDENTIAL			
Interview Arranged For:	Date:	Time:	<input type="checkbox"/> NO Interview
Position Interviewed:	Shift:		
Application Reviewed By:	Title:	Date:	Hired: <input type="checkbox"/> NO <input type="checkbox"/> YES, Hire Date:
REMARKS:			
Status:	<input type="checkbox"/> FT <input type="checkbox"/> PT I <input type="checkbox"/> PT II <input type="checkbox"/> Per Diem <input type="checkbox"/> Per Diem I <input type="checkbox"/> Per Diem II <input type="checkbox"/> Temp		
Child Abuse History Clearance Required: <input type="checkbox"/> YES <input type="checkbox"/> NO			
References Sent:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rate of Pay: \$	



Great Lakes Home Healthcare Services

HOME HEALTH AIDE APPLICANT BACKGROUND EXPERIENCE CHECKLIST

Name: _____ Date: _____

In order to help us assign you to appropriate cases and assess the need for in-service training sessions, please review the following checklist. Please check each item to indicate your level of experience: **YES** (experienced and comfortable), **SOME** (may need a review or refresher) or **NO** (no experience, need training).

TYPE OF PATIENT	YES	SOME	NO
Adolescent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amputee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aphasic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion, Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmentally Disabled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysphagic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotionally Disturbed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemiplegic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease/Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paraplegic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TYPE OF PATIENT (Cont.)	YES	SOME	NO
Pediatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quadriplegic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Terminal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trache Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ventilator Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TREATMENTS & PROCEDURES	YES	SOME	NO
Meal Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning of Patient's Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning of Bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning of Kitchen after Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient's Personal Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other home care experiences: _____

Special certification/training: _____



REFERENCE RELEASE

I hereby authorize Great Lakes Home Healthcare Services to contact any schools, current or former places of employment, law enforcement agencies, and/or persons who may aid in determining any suitability for employment. Additionally, I release those individuals and/or organizations contacted from all liability for issuing the requested information.

Print Name

Applicant's Signature

Date

If previous employment has been under another name please print your former name below.

Former Name

Position applied for



Great Lakes Home Healthcare Services

1700 Peach Street, Erie, PA 16501

REFERENCE CHECK REQUEST (Mail or Fax)

To: _____ Name of Applicant: _____

_____ Social Security #: _____

_____ Period Employed: _____

Applicant: Sign and return blank form with your application.

I authorize the above listed employer to release information concerning my employment to Great Lakes Home Healthcare Services.

APPLICANT'S SIGNATURE

DATE

Please provide your evaluation of this applicant who has applied for a position as _____ at Great Lakes Home Healthcare Services. All information will remain *strictly* confidential.

Factors	Performed	Beyond expected results	Acceptable	Unacceptable	Unknown	Additional Comments
➤ Interpersonal Relationships						
➤ Productivity						
➤ Quality of Work						
➤ Attendance						
➤ Punctuality						

Reason for Termination: Lay-off Voluntary Resignation Discharge Explanation: _____

Would you rehire? Yes No Conditional If **No** or **Conditional**, explain: _____

Signature: _____ Date: _____

TELEPHONE REFERENCE CHECK

(To be used only for by GLHHS Human Resources)

1. _____ has applied for the position _____. Would you serve as a reference? All information will remain confidential.
2. When did _____ Work for you? From: _____ To: _____
3. How would you describe the applicant's (see following)

	Rating	Performed	Beyond expectation	Acceptable	Unacceptable
➤ Interpersonal Relationships					
➤ Productivity					
➤ Quality of Work					
➤ Attendance					
➤ Punctuality					

4. Can you tell me about some of this individual's strengths, skills, or any weaknesses? _____

5. May I have your name and title? _____



Great Lakes Home Healthcare Services

1700 Peach Street, Erie, PA 16501

REFERENCE CHECK REQUEST (Mail or Fax)

To: _____
Name of Applicant: _____
Social Security #: _____
Period Employed: _____

Applicant: Sign and return blank form with your application.
I authorize the above listed employer to release information concerning my employment to Great Lakes Home Healthcare Services.

APPLICANT'S SIGNATURE _____ **DATE**

Please provide your evaluation of this applicant who has applied for a position as _____ at Great Lakes Home Healthcare Services. All information will remain *strictly* confidential.

Factors	Performed	Beyond expected results	Acceptable	Unacceptable	Unknown	Additional Comments
➤ Interpersonal Relationships						
➤ Productivity						
➤ Quality of Work						
➤ Attendance						
➤ Punctuality						

Reason for Termination: Lay-off Voluntary Resignation Discharge Explanation: _____
Would you rehire? Yes No Conditional If **No** or **Conditional**, explain: _____

Signature: _____ Date: _____

TELEPHONE REFERENCE CHECK

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1. _____ has applied for the position _____. Would you serve as a reference? All information will remain confidential.
2. When did _____ Work for you? From: _____ To: _____
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	Rating	Performed	Beyond expectation	Acceptable	Unacceptable
➤ Interpersonal Relationships					
➤ Productivity					
➤ Quality of Work					
➤ Attendance					
➤ Punctuality					

4. Can you tell me about some of this individual's strengths, skills, or any weaknesses? _____
5. May I have your name and title? _____

Notice of Summary of Your Rights under the Fair Credit Reporting Act

The Fair Credit Reporting Act (FCRA) – FCRA, 15 U.S.C. 1681-1681u – was established to ensure privacy of information, along with fairness and accuracy of information held in the data banks and files of Consumer Reporting Agencies, typically credit bureaus (BRA) across the .S. These CRAs collect and sell information about your credit status and credit worthiness.

To find regulation in its complete form visit the Federal Trade Commission's Website at :

<http://www.ftc.gov>

you may also have additional rights under state law. You may contact a consumer protection agency or a state attorney general to learn those rights.

Things you should know:

- **Anyone using information from a CRA to take action against you** such as denying credit, insurance, or employment, must tell you and give you the name, address, and phone number of the CRA that provided the consumer report.
- **At your request, A CRA must supply the information in your file and a list of everyone who has recently requested it.** There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of this action. You are also entitled to one free report every twelve months upon request if you certify that you are unemployed and plan to seek employment within 60 days, you are on welfare, or your report is inaccurate due to fraud. Otherwise you will be charged up to eight dollars.
- **You can dispute inaccurate information.** If you contact a CRA to inform them that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. The source must also advise national CRAs to which it has provided data of any error(s) that may have occurred. The CRA must give you a written report of the investigation and a copy of your report if the investigation results in any change. If the CRA's investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include a summary of your statement in any future reports. If an item is deleted or a statement of dispute is filed, you may ask that anyone who has recently received your report to be notified of the change.
- **A CRA must remove or correct inaccurate or unverified information from its files,** usually within 30 days after you dispute it. CRA is not required to remove accurate data from your files unless it is outdated as described below, or cannot be verified. If your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.
- **You can dispute inaccurate information with the source of that information.** If you dispute an item with someone such as a creditor who reports to a CRA, they may not then report the information to a CRA without including a notice of your dispute. Once you have notified the source of the error in writing, that source may not continue to report the information if the information is an error.
- **In general, a CRA may not report negative information that is more than 7 year old (bankruptcies 10 years).**
- **Access to your file is limited** in that a CRA may provide information about you only to people with a need recognized by the FCRA for purposes such as an application with a creditor, insurer, employer, landlord, or other business.
- **Your consent/permission is required for reports to be provided to employers, or for reports containing medical information about you.** A CRA may not report medical information about you to insurers, creditors or employers without your permission. A CRA may not distribute information about you to your employer or prospective employer without your consent.
- **You may choose to exclude your name from CRA lists for unsolicited credit and insurance offers.** Offers must include a toll-free phone number for you to call if you want your name/address removed from future lists. Your call will keep you off the lists for 2 years. Call a CRA to obtain a form that when completed and sent back will keep you off the list indefinitely.

You may seek damages from violators. If a CRA, a user or in some cases, a provider of CRA data violates the FCRA, you may sue them in state or federal court.