



APPLICATION FOR EMPLOYMENT

To Applicant: We appreciate your interest in our organization and assure you that we are sincerely interested in your qualifications. A clear understanding of your background and work history will aid us in placing you in the position that best meets your qualifications and may assist us in possible future upgrading. **Please answer ALL questions. Please print clearly, in ink.**

Name in Full: _____ Date: _____
(Last) (First) (Middle)

Address: _____
(No., Street) (City/Town) (State) (Zip Code)

Telephone Number: _____ Social Security Number: _____

Are you at least 18 years of age? Yes No. If no, what is your date of birth? _____

Position(s) applying for: _____ Rate of pay expected: \$ _____ per hour.

Days available: Mon. Tues. Wed. Thurs. Fri. Sat. Sun. Every weekend Alternate weekends

Number of hours per week _____ Times Available: _____

If your application is considered favorably, on what date will you be available for work? _____

What prompted you to apply here for employment? _____

Were you previously employed by us? Yes No. If yes, when? _____ Position? _____

Do you have any relatives working for us? Yes No. If yes, Names: _____

Do you have any friends working for us? Yes No. If yes, Names: _____

Please list any experiences, skills or qualifications that you feel would especially fit you for work with our organization: _____

Do you possess a valid New York State Driver's License? Yes No.

Date of your last physical examination: _____ Family physician: _____
(month/year)

(Turn to next page)

STATE AND FEDERAL LAWS PROHIBIT DISCRIMINATION ON THE BASIS OF RACE, COLOR, MARITAL STATUS, CREED, SEX, NATIONAL ORIGIN, SPONSOR, DISABILITY, HANDICAP, AGE, VETERAN STATUS, OR SEXUAL PREFERENCE.

EMPLOYMENT RECORD

List all present and past positions, beginning with the most recent.

1) Employer: _____ Phone: (____) _____
Street Address: _____ City: _____ State: _____ Zip: _____
Title/Position Held: _____ Supervisor/Title: _____
Dates of Employment: _____ to _____ Last Hourly Pay Rate: \$ _____
Reason for Leaving: _____
Summary of Responsibilities: _____

2) Employer: _____ Phone: (____) _____
Street Address: _____ City: _____ State: _____ Zip: _____
Title/Position Held: _____ Supervisor/Title: _____
Dates of Employment: _____ to _____ Last Hourly Pay Rate: \$ _____
Reason for Leaving: _____
Summary of Responsibilities: _____

3) Employer: _____ Phone: (____) _____
Street Address: _____ City: _____ State: _____ Zip: _____
Title/Position Held: _____ Supervisor/Title: _____
Dates of Employment: _____ to _____ Last Hourly Pay Rate: \$ _____
Reason for Leaving: _____
Summary of Responsibilities: _____

4) Employer: _____ Phone: (____) _____
Street Address: _____ City: _____ State: _____ Zip: _____
Title/Position Held: _____ Supervisor/Title: _____
Dates of Employment: _____ to _____ Last Hourly Pay Rate: \$ _____
Reason for Leaving: _____
Summary of Responsibilities: _____

5) Employer: _____ Phone: (____) _____
Street Address: _____ City: _____ State: _____ Zip: _____
Title/Position Held: _____ Supervisor/Title: _____
Dates of Employment: _____ to _____ Last Hourly Pay Rate: \$ _____
Reason for Leaving: _____
Summary of Responsibilities: _____

6) Employer: _____ Phone: (____) _____
Street Address: _____ City: _____ State: _____ Zip: _____
Title/Position Held: _____ Supervisor/Title: _____
Dates of Employment: _____ to _____ Last Hourly Pay Rate: \$ _____
Reason for Leaving: _____
Summary of Responsibilities: _____

1. May we contact all employers listed on the previous page? Yes No.
If not, indicate by number which ones you do not want us to contact:_____.
2. Is additional information, relative to a change of name, necessary to enable a check on your work record? Yes No.
If yes, please explain:_____
3. Have you ever collected unemployment insurance benefits? Yes No. If yes, when?_____ For how long?_____
4. Have you ever been convicted of any felony, misdemeanor, or other offense? Yes No. If yes, this does not automatically disqualify you for employment. Please provide details:_____
5. Have you ever been convicted of resident/patient abuse? Yes No. If yes, please provide details:_____

SCHOOL RECORD

High School Name:_____	Course of Study:_____
Street Address:_____	Number of years attended:_____
City:_____ State:_____ Zip:_____	Did you graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No.

College Name:_____	Course of Study:_____
Street Address:_____	Number of years attended:_____
City:_____ State:_____ Zip:_____	Did you graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No.

Trade or Other School Name:_____	Course of Study:_____
Street Address:_____	Number of years attended:_____
City:_____ State:_____ Zip:_____	Did you graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No.

If you possess specialized training, please explain in full:_____

Nurses, CNA's and Technicians - Registration Number:_____ Expiration Date:_____ State:_____

PERSONAL REFERENCES (Do not include relatives or former employers)

- 1) Name:_____ Occupation:_____
- Street Address:_____ City:_____ State:_____ Zip:_____
- 2) Name:_____ Occupation:_____
- Street Address:_____ City:_____ State:_____ Zip:_____
- 3) Name:_____ Occupation:_____
- Street Address:_____ City:_____ State:_____ Zip:_____

The facts set forth in my application are true and complete. I understand that if employed, false statements on this application shall be considered sufficient cause for dismissal. Schofield Home Health Care Services is hereby authorized to make any investigation of my personal history and financial and credit record through any investigative or credit agencies or bureaus of your choice. I authorize the representatives of Schofield Home Health Care Services to contact my present and former employers and all personal references listed. I understand that I must pass a physical examination and provide sufficient proof under the Immigration Reform Act that I am eligible for employment. I recognize and agree that I am not being employed for any set period of time; I can terminate my employment at any time and Schofield Home Health Care Services reserves the right to do the same.

Applicant Signature:_____ **Date:**_____

SCHOFIELD HOME HEALTH CARE SERVICES, INC.

Applicant Name: _____

Please indicate below by checking "yes" or "no" whether you ever have or have not worked at the following health care facilities:

Facility Name	Yes	No	Facility	Yes	No
Advanced Home Care of WNY, Inc.			The Gardens of Manhattan		
Aftercare Nursing Services, Inc.			Genesee County Nursing Home		
All Metro Home Care			Gerry Nursing Home (Heritage Village)		
Allcare Family Services, Inc.			Goodcare Home Health		
Allegany Nursing Home			Gowanda Nursing Home		
Allstate Home Care of Buffalo, Inc.			Grace Manor		
Alterra Wynwood			Greenfield Health Care Facility		
Alterra Clarebridge			Hamburg Health Care Center		
Amherst Nursing & Convalescent Home			Harris Hill Nursing Facility		
Aurora Home Care			Health Care Plan, Inc. – Homecare		
Aurora Park Health Care Center			Health Force		
Autumn View Manor			Heathwood Health Care Center		
Baker Victory Services			Heritage Village		
Bassett Manor			High Street Home Health Service, Inc.		
Batavia Nursing Home			Holystic Home Care, Inc.		
Beechwood Residence & Nursing Home			Home Care Buffalo		
Bertrand Chaffee Hospital			Home Care Support Service, Inc.		
Briody Nursing Home			Hospice		
Brothers of Mercy Nursing Facility			Houghton Nursing Care Center		
Bry-Lin Hospital			Independent Nursing Care		
Buffalo Columbus Hospital			Intercommunity Memorial Hospital		
Buffalo General Hospital			Interim Health Care of Buffalo		
Buffalo Medical Group			Jennie B. Richmond Chaffee N. H.		
Buffalo Psych Center			Kenmore Mercy Hospital		
Canterbury Woods			Kresge Residence		
Caregivers			Lake Shore Hospital		
Cattaraugus County Home & Infirmary			Lake Shore Nursing Home		
Cattaraugus County Public Nursing			Leroy Village Green Nursing Home		
Catholic Charities of Buffalo Home Care			Linwood Health Care Facility		
Chautauqua County Home			Lockport Memorial Hospital		
Children's Hospital			Lutheran Social Services		
Children's Hospital Home Care			Lutheran Retirement Home		
Coram Healthcare Corporation of NY			Manor Home Health Care		
Crestwood Health Care Facility			Manor Oak		
Cuba Memorial Hospital			Maplewood Health Care Facility		
Deaconess Nursing Facility			Mary Agnes Manor		
DeGraff Memorial Hospital			Maxim Health Care		
Delaware Heights			McAuley Residence Nursing Facility		
EGW Home Care Inc.			McAuley Seton Home Care		
East Side Nursing Home			Medina Memorial Hospital		
Episcopal Church Home & Residential Facility			Menorah Campus Adult Home, Inc.		
Episcopal – General Homecare, Inc.			Mercy Home Care of WNY		
Erie County Home & Infirmary			Mercy Hospital and Nursing Facility		
Erie County Medical Center			Millard Fillmore Gates Circle		
ECMC Home Health Service			Millard Fillmore Suburban Hospital		
Fairchild Manor Nursing Home			Mount St. Mary's Hospital of Niagara Falls		
Family Care Services of WNY, Inc.			Mount St. Mary's LT Care Facility		
Father Baker Manor			Mount View Health Facility		
Fiddlers Green Manor Nursing Home			NMC Health Care		
Garden Gate Manor			Nazareth Nursing Home		

Facility	Yes	No	Facility	Yes	No
Newfane Health Facility			St. Luke's Presbyterian Nursing Center		
Niagara Falls Memorial Medical Center			St. Mary's Manor		
Niagara Frontier Nursing Home			St. Vincent's Home for the Aged		
Niagara Geriatric Center			Salamanca Nursing Home		
Niagara Lutheran Health & Rehabilitation			Schoellkopf Health Care		
Norrell Health Care			Schofield Residence		
North Gate Manor			Schofield Home Health Care Services, Inc.		
Nursefinders			Seneca Manor		
Oakwood Health Care Facility			Sheehan Emergency Hospital		
Odd Fellow & Rebekah Nursing Home			Sheridan Manor Nursing Home		
Olean General Hospital			Sisters of Charity Hospital		
Olsten Kimberly Quality Care			Sisters of Charity Hospital LTHHCP		
Orchard Manor Nursing Home			SPS Home Care, Inc.		
Orchard Park Health Care Center			Staff Builders Home Health Care		
Orleans County Home & Infirmary			Supplemental Staffing Services, Inc.		
Our Lady of Peace Nursing Home			The Waters		
Our Lady of Victory Hospital			Tonawanda Manor		
Parkshore Health Care Center			United Church Home		
People, Home Health Care Services			United Memorial Medical Center		
Presbyterian Homes of WNY			Univera Healthcare – Home Care		
24 Rhode Island Street Nursing Home			VA Medical Center		
Ridge View Manor Nursing Home			Village Park Health Facility		
Riverwood Nursing Home			Visiting Nursing Association of WNY, Inc.		
Rosa Coplon Jewish Home & Infirmary-LT			Waterfront Medical Center		
Roswell Park Cancer Institute			Wedgewood HCF		
St. Andrew's Presbyterian Manor			Weinberg Campus		
St. Augustine's Center, Inc.			Wellsville – Highland		
St. Catherine Laboure Health Care Center			Wellsville Manor Nursing Home		
St. Clare Manor			Westfield Memorial Hospital		
St. Columban's on the Lake			Wheel Chair Home, Inc.		
St. Francis Home of Williamsville			Willcare, Inc.		
St. Francis Geriatric & Healthcare			Williamsville Suburban Nursing Home		
St. Joseph Intercommunity Hospital			Williamsville View Manor		
St. Joseph's Manor			Wyoming County Community Hospital		
St. Luke Manor					

Please list every SNF, ACF or IHF where you have worked that is not included on this list.

I hereby certify that this information is true and correct. I understand that if I am employed, any misrepresentation of the facts as stated or implied on this form is sufficient cause for dismissal.

Signature of Applicant

Date



CONFIDENTIAL REFERENCE REQUEST

Date: _____
 TO: _____

RE: Name _____
 Address _____

 Social Sec. # _____

The individual above has applied for a position as a(n) _____ at the Schofield Home Health Care facility. With the applicant's permission, per the INFORMATION DISCLOSURE section below, we are requesting the applicable reference checked below (employment reference or character reference). All information will be held in strict confidence. Your earliest attention to this request will be helpful. Thank you for your cooperation.
 Sincerely, Deborah Cammarano, Personnel Supervisor

INFORMATION DISCLOSURE: I hereby authorize you to disclose to the Schofield Home Health Care Facility any information concerning my association with you or your organization.

Applicant's Name: _____ **Applicant's Signature:** _____

EMPLOYMENT REFERENCE

Correct Info:

1. Was the applicant in your employ from _____ to _____ ? YES NO: _____
2. Was his/her position or title _____ ? YES NO: _____
3. Did he/she leave due to _____ ? YES NO: _____
4. Would you rehire this individual? YES NO - If no, please indicate reason: _____

5. Please rate the individual on the following:

	Did not meet standards	Met standards	Exceeded standards	N/A
Attendance/Reliability				
Quality/Quantity of work				
Attitude/Cooperation				
Initiative				

6. Are you aware of any reason this individual should not work with the frail elderly? NO YES --
 If yes, please explain: _____
7. Additional comments: _____

Signature: _____ Title: _____ Date: _____

CHARACTER REFERENCE

1. In what capacity do you know the applicant? _____
2. How long have you known the applicant? _____
3. Are you aware of any reason this individual should not work with the frail elderly? NO YES --
 If yes, please explain: _____
4. Additional comments: _____

Signature: _____ Occupation: _____ Date: _____

(Complete this page, only if applying for Home Health Aide Training)

**Schofield Home Health Care Services, Inc.
HHA Training Questionnaire**

Name _____

Date _____

Please answer each question.

1. How did you hear about Schofield?

- Buffalo News Other Newspaper _____ Sign
 Schofield Home Health Care Employee Schofield Residence Employee
 Word of Mouth Telephone Book Other _____

2. Aside from helping others, why do you want to be a home health care aide?

3. What duties would you expect to have as a home health aide? Please list all you are aware of:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

4. List some negative aspects of the job that you would expect to encounter as a home health aide.

5. What traits/characteristics do you think a successful home health aide must have?

6. How do you feel about old people who are crabby and confused?
