



*Nancy's Home Care Agency*  
400 East 41<sup>st</sup> Suite 114B  
Chicago, IL 60653  
Phone: (872) 221-0283  
[www.nancyshomecare.com](http://www.nancyshomecare.com)

Thank you for your interest in *Nancy's Home Care Agency*.

*Nancy's Home Care Agency* provides experienced, compassionate care to seniors and their families looking for reliable, trustworthy Caregivers. We receive many inquiries each day from people who are interested in qualifying to be on our first-rate care provider team.

To be considered as a team member with ABC, the following must be met:

1. Minimum 1+ years of experience providing care within the industry.
2. A dependable vehicle properly insured.
3. Valid *State* driver's license.
4. You must be trustworthy and dependable.

In addition to meeting the above criteria, the following documentation will be required:

1. Recent copy of your driver's license report (within last 6 months).
2. Copy of recent TB (Tuberculosis) screening (within last 6 months).
3. Background check completed.
4. Any certifications or degrees you may have earned.
5. Minimum of 3 verifiable professional references.

If you can meet all of the above, then completely read and fill out the enclosed Application.

When you have completed the Application, please fax, return by mail or drop off at our office listed above.

Thank you for your interest.

Sincerely,

*Nancy's Home Care Agency*



# Caregiver Employment Application

By filling out this application and questionnaire, you are applying for employment at *Nancy's Home Care Agency*. This company is dedicated to a policy of non-discrimination of applicants on any basis including race, color, age, sex, religion, disability, medical condition, national origin, or marital status.

Your Full Name		Date	
Street Address		City	State      Zip
Home Phone	Cell Phone	Tax ID / SSN #	Do you smoke? <input type="checkbox"/> yes <input type="checkbox"/> no
Date of Birth (Optional)	Ethnicity (Optional)	How did you hear about us:	

<b>Alternate Contact</b>	
Name	Phone
Address	Relationship

Are you currently employed / provide Care to others?      Explain: If Yes, Explain. <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted of a misdemeanor/felony? If Yes, provide details <input type="checkbox"/> yes <input type="checkbox"/> no      Details:

<b>Transportation</b>		
Most clients require transportation, often using the Care Provider's vehicle:		
Do you have dependable transportation? <input type="checkbox"/> yes <input type="checkbox"/> no	Make and model car	
License plate #	Driver license #	Auto insurance policy #
Insurance company	Insurance agent name	Insurance agent phone

<b>Availability</b>			
Appx. hours per week available:	Days/Times you <b>are</b> available	Days & times <b>not</b> available	Can you be called at the last minute in case of emergency? <input type="checkbox"/> yes <input type="checkbox"/> no
Select the areas that you will accept work: <input type="checkbox"/> City 1 <input type="checkbox"/> City 2 <input type="checkbox"/> City 3 <input type="checkbox"/> City 4 <input type="checkbox"/> City 5			

### What Education Qualifies You To Work As a Caregiver?

High school	City/State	Dates
College	City/State	Dates
Other	City/State	Dates
Degrees/certificates – All Degrees / Certificates must be presented copy. All will be verified with provider/issuer.		
Special skills or courses – Any skills that assist in making you qualified as a professional Care Provider.		

### What is Your Past Experience?

Discuss any training or experience working with the elderly. How are you trained and/or experienced in working with the elderly?

What do *YOU* do that shows and proves you're Reliable, Trustworthy and Honest?

What would you like least about working with the elderly?

### Skills

Please indicate which of the following skills you are prepared to provide if referred to seniors / families:

Companion Care & Safety	<input type="checkbox"/> yes <input type="checkbox"/> no	Medication reminders	<input type="checkbox"/> yes <input type="checkbox"/> no	Oral Care	<input type="checkbox"/> yes <input type="checkbox"/> no
Alzheimer's	<input type="checkbox"/> yes <input type="checkbox"/> no	Transportation	<input type="checkbox"/> yes <input type="checkbox"/> no	Shaving Assistance	<input type="checkbox"/> yes <input type="checkbox"/> no
Dementia	<input type="checkbox"/> yes <input type="checkbox"/> no	Bathing (Reg., bed, sponge)	<input type="checkbox"/> yes <input type="checkbox"/> no	Assist w / P.T. Exercises	<input type="checkbox"/> yes <input type="checkbox"/> no
Meal Prep / Clean Up	<input type="checkbox"/> yes <input type="checkbox"/> no	Dressing/ Grooming	<input type="checkbox"/> yes <input type="checkbox"/> no	Assist w/ Prosthesis	<input type="checkbox"/> yes <input type="checkbox"/> no
Feeding	<input type="checkbox"/> yes <input type="checkbox"/> no	Incontinence	<input type="checkbox"/> yes <input type="checkbox"/> no	Hospice	<input type="checkbox"/> yes <input type="checkbox"/> no
Light Housekeeping	<input type="checkbox"/> yes <input type="checkbox"/> no	Ambulation	<input type="checkbox"/> yes <input type="checkbox"/> no	Willing to Work w/Pets	<input type="checkbox"/> yes <input type="checkbox"/> no
Laundry	<input type="checkbox"/> yes <input type="checkbox"/> no	Transfer assist	<input type="checkbox"/> yes <input type="checkbox"/> no	Speak fluent English	<input type="checkbox"/> yes <input type="checkbox"/> no

**Work History**

Please provide at least five years of recent, verifiable work history followed by verifiable references.

Company	From	To
Job title	Reason left	
Duties		
Supervisor	Phone	
Company	From	To
Job title	Reason left	
Duties		
Supervisor	Phone	
Company	From	To
Job title	Reason left	
Duties		
Supervisor	Phone	

**Why Do You Feel You Would Be An Excellent Addition to Our Team?**

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**Business | Professional References**

Name	Address	Relationship/Years Known	Local Phone #
Name	Address	Relationship/Years Known	Local Phone #
Name	Address	Relationship/Years Known	Local Phone #

**Character & Personal References**

Name	Address	Relationship/Years Known	Local Phone #
Name	Address	Relationship/Years Known	Local Phone #
Name	Address	Relationship/Years Known	Local Phone #

**CERTIFICATION AND RELEASE:** I certify that I have read and understand the general requirements of Independent Care Contractors/Providers on page one of this form and that the answers given by me to the foregoing questions and the statements made by me are complete and true to the best of my knowledge and belief. I completely understand that I am submitting this Application as an interested Care Provider and that by submitting this there is no guarantee for employment. I understand that any false information, omissions, or misrepresentation of facts called for in this application may result in rejection of my application. I authorize the company and/or its agents, including consumer reporting bureaus, to verify any information including, but not limited to, work, criminal and credit history and motor vehicle driving records. I authorize all persons, schools, companies, and law enforcement authorities to release any information concerning my background and hereby release any said persons, schools, companies, and law enforcement authorities from any liability for any damage whatsoever for issuing this information.

Signature	Date
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**For Office Use Only – Interview/Comments/Reference Check /Notes**