POSITION APPLYING FOR		DATE
LAST NAME	FIRST NAME	MIDDLE NAME

Thank you for considering Assured Home Healthcare Inc. for employment.

This application is available upon request from our office location in person, email attachment, or downloaded from our website. Please print the application, if obtained electronically, and completely fill out the application in black ink or typed print and sign. Submit your application via in-person to our office location, mail, fax, or as an email attachment, if applicable. You can submit your resume along with this application as well.

Assured
Home Healthcare

1947 Harder Ct. Ste B
Schererville, IN 46375-1696

Office: 219-322-7664
Toll free: 219-322-7660
Fax: 219-322-7109

Office hours of operations:
Monday thru Friday
9:00AM – 5:00PM

Website: HomeHealthyNow.com
Email: assured@HomeHealthyNow.com

How did you hear about this agency? ☐Referral or word-of-mouth by: _____
☐Phonebook: _____ ☐Website: _____ ☐Other: _____
Do you have relatives or friends at this agency? ☐No ☐Yes If yes, who? _____

Main phone number ☐cell* ☐home ☐work ☐fax	Alternate phone 2 ☐cell* ☐home ☐work ☐fax	Alternate phone 3 ☐cell* ☐home ☐work ☐fax

Do you text*? ☐ Yes ☐ No	Would you accept texting* as a means of communication with us? ☐ Yes ☐ No	What is your texting* number above? ☐ Main ☐ Alt 2 ☐ Alt 3

Please note Assured Home Healthcare, Inc. does not promote cellular use or texting while driving.

What is your age?	Email address:	Social Media:

Within the past two (2) years, have you lived outside of the state of Indiana? ☐ Yes ☐ No

1. Current residential address	City	County	State	Zip	How long? From ____ to present.
2. Previous residential address	City	County	State	Zip	How long? From ____ to _____.
Mailing address, if different from above; or 3. Previous residential address	City	County	State	Zip	How long? From ____ to _____.

Please further provide a complete address history and names associated with your identity on last page of this application.

Have you been convicted a felony? ☐ Yes ☐ No
If yes, please read paragraph and then describe below:

As of June 30, 2010; Indiana Code 16-27-2-4 Section 5 states in the following: home health agencies in Indiana as Assured Home Healthcare, Inc. may not employ a person to provide services in a patient's temporary or permanent residence if that person's limited criminal history, national criminal history background check, or expanded criminal history check indicates that the person has been convicted of (1) rape (IC 35-42-4-1), (2) criminal deviate conduct (IC 35-42-4-2), (3) exploitation of an endangered adult (IC 35-46-1-12), (4) failure to report battery, neglect, or exploitation of an endangered adult (IC 35-46-1-12), (5) theft (IC 35-43-4) if the conviction for theft occurred less than ten (10) years before the person's application date, a felony that is substantially equivalent to a felon listed in (A) subdivisions (1) through (4); or subdivision (5), if the conviction for theft occurred less than ten (10) years before the person's employment application date; for which the conviction was entered in another state.

_____

_____

Are you excluded by the Office of Inspector General of the U.S. Department of Health Human Services to participate in Federally funded health care programs, such as Medicare or Medicaid? ☐ Yes ☐ No

Driving history:

In the past three (3) years, have you had any **minor/major** vehicle accident(s) and/or moving violation(s)? ☐ Yes ☐ No

In the past one (1) year, have you had any **major** vehicle accident(s) and/or moving violation(s)? ☐ Yes ☐ No

If yes to either of the above, please describe further: _____

_____

Do you use any of the following: Tobacco?☐Y ☐N Vaporizers?☐Y ☐N Alcohol?☐Y ☐N Drugs?☐Y ☐N

Will you submit to drug screening as it may be required by state law for employment? ☐ Yes ☐ No

Are you a U.S. Citizen or immigrant legally authorized to work in the United States? ☐ Yes* ☐ No

*If Yes, please be able to at least provide your Driver's License and Social Security Card.

Please, describe the funniest thing that has ever happened to you on the job:

Describe patient care service and how you would apply that in home health care if employed with Assured Home Healthcare, in your own words:

Are you applying for:	Desired salary:	Career goal(s):
☐ Full time ☐ Part time ☐ Temporary ☐ As needed		

Earliest available start date:	Preferable days and times of availability for work: Times: Days: Weekends: Nights: Holidays:

PROFESSIONAL LICENSES, REGISTRATIONS, AND/OR CERTIFICATIONS

Type:	State issued:	Expiration date	Number:	Status:
				☐Active ☐Expired ☐Other
				☐Active ☐Expired ☐Other
				☐Active ☐Expired ☐Other

Other licenses, registrations, and/or certifications; or area of specialization or major interest: _____

Specialty certifications, if any: _____

CPR certified ☐ Yes ☐ No Expiration date: _____	Other certifications (ACLS, PALS, instructor, etc.): _____

*Please be able to provide certification cards above.

List health care setting(s), business, computer programs, or health equipment used or experienced with:

EDUCATION

School	Name	Course of study	Dates of attendance	Did you graduate?	List degree or diploma
☐Graduate ☐College ☐High school			From: To:	☐Yes ☐ No	
☐Graduate ☐College ☐High school			From: To:	☐ Yes ☐ No	
☐Graduate ☐College ☐High school			From: To:	☐ Yes ☐ No	

Other colleges/schools, other special courses and/or training:

Have you served in a U.S. armed service branch? ☐ Yes ☐ No If yes, which branch? _____

Do you have plans for further education, training, or certifications? ☐Yes ☐ No If Yes, please specify:

PREVIOUS WORK EXPERIENCE				
Job title	From	To	Immediate supervisor	Last salary
Employer	Address/street/city/state		Phone	
Description of duties:				
Reason for leaving:				
Job title	From	To	Immediate supervisor	Last salary
Employer	Address/street/city/state		Phone	
Description of duties:				
Reason for leaving:				
Job title	From	To	Immediate supervisor	Last salary
Employer	Address/street/city/state		Phone	
Description of duties:				
Reason for leaving:				
Job title	From	To	Immediate supervisor	Last salary
Employer	Address/street/city/state		Phone	
Description of duties:				
Reason for leaving:				
Can we run a detailed employment check, including but not limited to a check with your previous employer? ☐ Yes ☐ No				
State the reason you do not want us to contact any of the above listed employers above.				
REFERENCES: List at least 3 references who are not relatives or previous employers.				

Name	Relationship	Title & Company	Contact no.	Mailing address and/or email address

Further complete address history and any other names associated with your identity.					
Previous residential address 4	City	County	State	Zip	How long? From ____ to _____.
Previous residential address 5	City	County	State	Zip	How long? From ____ to _____.
Previous residential address 6	City	County	State	Zip	How long? From ____ to _____.

Other names associated with your identity (if any): _____

_____

Any immediate questions regarding possible employment at this time?: _____

_____

_____

CAREFULLY READ THIS SECTION PRIOR TO PROVIDING SIGNATURE BELOW

I understand that my application process is subject to approval for employment and will be under consideration due to my qualifications, criminal history check nationally and in all state counties ever resided, sex offender searches, and any risk for the reasons Assured Home Healthcare, Inc. follows under federal, state, and local laws and codes in accordance to their company and employment policies.

I understand that an offer of employment would be subject to my satisfactorily passing a physical examination. I consent to and will obtain a physical examination by a physician or nurse practitioner at that time and at any future time. I understand that I may be required to satisfactorily complete an alcohol/drug screening as a condition of employment. I understand that the Agency is a health care provider and may have a no-smoking policy and I agree to comply with its requirements.

I understand that my employment can be terminated at any time and for any reason, at the option of either the facility or myself. I understand that no one has the authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the foregoing, except for a written employment agreement signed by and administrative representative of this Agency.

I hereby affirm that the information provided on this application (and accompanying resume, if any) is true and complete. I understand that any false or misleading representations or omissions may disqualify me form further consideration for employment and may result in discharge even if discovered at a later date.

I hereby authorize and request without reservation any persons, schools, my current and previous employer(s), and organizations named in this application (and accompanying resume, if any), as well as police department, financial institution, division of motor vehicles, consumer reporting agencies, or other persons or agencies having knowledge about me, to provide Assured Home Healthcare, Inc. and all its affiliates with any relevant background information in their possession regarding me, in order my employment qualifications may be evaluated, and release all such persons from any liability regarding the provision or use of such information.

Signature of applicant:	Date: