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A division of
Jewish Family and Children's Services

2150 Post Street, San Francisco, CA 94115
 200 Channing Street, Palo Alto, CA 94301-2415
 2001 Winward Way, San Mateo, CA 94404
 600 5th Avenue, San Rafael, CA 94901-3348
 1360 North Dutton Avenue Suite C, Santa Rosa, CA 95401

Employment Application

Date: _____

Name: _____ Social Security #: _____

Address: _____ City, State, Zip: _____

Home telephone: _____ Cell phone: _____

Email address: _____

Emergency Contact information:

List individuals we can contact in cases of emergencies

Name 1: _____ Relationship: _____ Contact # _____

Name 2: _____ Relationship: _____ Contact # _____

Name 3: _____ Relationship: _____ Contact # _____

Have you worked for Seniors At Home/JFCS in the past? Yes No

If yes, what year? _____ Reason for leaving? _____

If no, how did you hear about Seniors At Home? Friend Newspaper Other

Referral or source name: _____

Do you have the legal right to work in the United States? Yes No

(If Yes, you are required to provide documented proof of your eligibility.)

Are you willing to be fingerprinted for DOJ and FBI clearance? Yes No

Work Preferences:

Circle the position you are most interested in: Live- In Attendant / Hourly Attendant

How many days are you available to work? : 1, 2, 3, 4, 5, 6, 7.

How many hours per shift are you available?: 2hrs, 4hrs, 8hrs, 12hrs, 24hr/live-in

Indicate as best as you can, the days and shifts you are available to work:

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------------------|--------|---------|-----------|----------|--------|----------|--------|
| Day (7am-3pm) | | | | | | | |
| PM (3pm- 11pm) | | | | | | | |
| Nights (11pm- 7am) | | | | | | | |

Client Preferences:

- You prefer to work with- Male clients only- Yes No
Female clients only- Yes No
Both male and female clients- Yes No
Single clients only- Yes No
Multiple clients- Yes No

- Are you allergic to the following? Cats- Yes No
Dogs- Yes No
Other animals- Yes No List: _____
Fragrance- Yes No
Smoke/cigarettes- Yes No
Any other allergies- Yes No List: _____

Able to work in a "smoking" home?- Yes No

Additional Information:

Other languages spoken: _____

List other special skills or experiences that you have used or have come across in homecare? (For example: Sewing, beautician, barbering, gardening, cooking, singing, etc) :

Driving and Areas of work: (check all area that you are willing to work in)

San Francisco Area: San Francisco only

North Peninsula Area: South SFO / Daly City / Pacifica / San Bruno / Hillsborough /
 Millbrae / Burlingame / San Mateo / Foster City / San Carlos

South Peninsula Area: Redwood City / Palo Alto / Menlo Pk / Sunnyvale / Sta. Clara /
 Mt. View / San Jose

Marin/Sonoma: Sausalito / Mill Valley / San Rafael / Tiburon / Novato /
 Kentfield / Ross / Fairfax / San Anselmo / Corte Madera /
 Larkspur / Greenbrae / Rohnert Park/ Petaluma / Santa Rosa /
 Sebastopol / Sonoma / Windsor / Cotati / Penngrove /
 Oakmont / Healdsburg

- Do you drive? Yes No
Do you have a valid driver's license? Yes No License #: _____
Are you willing to drive a client in your car? Yes No
Are you willing to drive a client's car? Yes No
Can you provide proof of car insurance? Yes No (Provide copy)

Certifications:

Provide copies of certifications during the hiring process.

Are you certified for CPR? Yes No

Do you have First Aid training? Yes No

Are you currently certified as a: CNA CHHA LVN RN ?

Training and Education:

School

Field of Study

Certificate/Degree

Work Experience:

Please list your most recent employers first.

1. Employer (Client's Name): _____

Address: _____

Supervisor's name / Phone number: _____

Employment dates From: _____ To: _____ Salary: _____

Position held: _____ Schedule: _____

How many patients did you care for in a shift?: _____

Duties and Responsibilities:

Reason for leaving: _____

Request for Reference Information Completed

2. Employer (Client's Name): _____

Address: _____

Supervisor's name / Phone number: _____

Employment dates From: _____ To: _____ Salary: _____

Position held: _____ Schedule: _____

How many patients did you care for in a shift?: _____

Duties and Responsibilities:

Reason for leaving: _____

Request for Reference Information Completed

3. Employer (Client's Name): _____

Address: _____

Supervisor's name / Phone number: _____

Employment dates From: _____ To: _____ Salary: _____

Position held: _____ Schedule: _____

How many patients did you care for in a shift?: _____

Duties and Responsibilities:

Reason for leaving: _____

Request for Reference Information Completed

I certify that all information given on this application is true and correct. I also understand that the Jewish Family and Children's Services may make an investigation of my work and personal history, and I authorize all persons, schools, companies, corporations and law enforcement agencies to supply any information concerning my background and release them from any liability and responsibility arising from their doing so. I understand that any misrepresentation or omission of information will be sufficient cause for dismissal.

Name

Date

Name: _____

Date: _____

Self Evaluation of Skill and Experience Inventory for
Personal Care Attendant

Please select the level of your skill and ability using the following KEY:
NA= not applicable 1= not experienced 2= some experience 3= very experienced

| | Skill/ Experience | Check One | Comments |
|----|-------------------------------------|--|----------|
| 1. | Personal Care Skills | | |
| | a. Bed Bath | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | b. Sponge, Tub or Shower Bath | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | c. Shampoo in Bed | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | d. Shampoo – Sink or Tub | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | e. Nail and Foot Care | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | f. Skin Care | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | g. Backrub/ Massage | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | h. Oral Hygiene/ Denture Care | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | i. Shave | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | j. Positioning | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | k. Make Occupied Bed | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | l. Dressing | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| 2. | Simple Procedures | | |
| | a. TPR / Vital Signs | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | b. Urine Test for Sugar | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | c. Safe Use of O ₂ | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | d. Non-Sterile Dry Dressing | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | e. Dry and Moist Heat | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | f. Cold Application | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| 3. | Elimination | | |
| | a. Intake and Output | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | b. Ostomy Care | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | c. Catheter Care | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | d. Bed Pan | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | e. Urinal | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | f. Incontinence/ Adult Diapers | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| 4. | Medication | | |
| | a. Reminding, Observing, Reporting | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | b. Assisting with Bottle or Mediset | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| 5. | Transfers/ Rehabilitation | | |
| | a. Standby | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | b. Minimum | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | c. Moderate | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | d. Maximum | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |

Please select the level of your skill and ability using the following **KEY**:
NA= not applicable **1**= not experienced **2**= some experience **3**= very experienced

| Skill/ Experience | | Check One | Comments |
|-------------------|---|--|----------|
| | e. Ambulation | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | f. Assistive Devices (cane, walker, wheel chair) | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | g. Hoyer Lifts / mechanical lift | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | h. Practices Good Body Mechanics & Transfers | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | i. Range of Motion/ Exercise | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| 6. | Infection Control | | |
| | a. Hand washing | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | b. Proper Bag Technique | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | c. Protective Equipment (gloves, mask, etc.) | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | d. Exposure Plan | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | e. Equipment Care | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| 7. | Meal Planning and Preparation | | |
| | a. Shopping and errands | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | b. Preparing Regular Diet | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | c. Preparing Modified Diet | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | d. Assist with Feeding | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| 8. | Provides Clean, Safe Environment | | |
| | a. Laundry | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | b. Dishes | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | c. General Housekeeping | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | d. Provides for Safety Needs of Client, Self and Others Present | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| 9. | Experience with the Following: | | |
| | a. Terminal Illness/ Cancer | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | b. Dementia/ Alzheimer's | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | c. AIDS | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | d. Parkinson's | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | e. Diabetes | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | f. Hip/ Bone Fractures | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | g. Mental Illness/ Depression | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | h. Stroke | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | i. Men | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |
| | j. Women | <input type="radio"/> NA <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 | |

Applicants: Print this page and give it to your employer references



Please return the document to:

- _____ 2150 Post Street, San Francisco, CA 94115or Fax: (415) 449-3703
- _____ 600 Fifth Avenue, San Rafael, CA 94901 or Fax: (415) 449-3703
- _____ 200 Channing Street, Palo Alto, CA 94301-2415 or Fax: (650) 330-0868
- _____ 2001 Windward Way, San Mateo, CA 94404or Fax: (650) 330-0868
- _____ 1360 N. Dutton Ave, Suite C, Santa Rosa, CA 95401 or Fax: (415) 449-3703

CONFIDENTIAL REQUEST FOR REFERENCE INFORMATION

To: _____

Applicant's Full Name _____ Soc Security # _____

The above named individual has applied to join our Home Care Agency. As we place great importance in the thorough screening of all our applicants, we would appreciate your courtesy in responding to us. This information will be held in the strictest confidence unless otherwise required by law. Thank you.

Sincerely,

Seniors At Home Staff

I hereby release from any liability the company; institution or person named above and authorize them to release all information regarding my employment with them.

Applicant's Signature _____

Date _____

Name of company: _____

Dates of Employment: From: _____ To: _____

Position Held: _____

Duties: _____

Reason for Termination: _____

Would you rehire this individual? Yes: _____ No: _____

| | Above Average | Average | Below Average |
|---------------------|---------------|---------|---------------|
| Quality of Skills | | | |
| Quality of Attitude | | | |
| Dependability | | | |
| Reliability | | | |
| Judgment | | | |

Additional Comments: _____

Client/Employer Signature & Title: _____