SERVANT’S HEART

 HOME CARE, LLC  *Serving With Purpose*

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CNA: \_\_\_\_\_\_\_\_\_ PCA:\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CIRCLE SHIFTS/HOURS YOU ARE AVAILABLE TO WORK.

 DAYS AFTERNOONS OVERNIGHT WEEKENDS LIVE-IN

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ITEMS BELOW THIS LINE FOR OFFICE USE ONLY**

ORIENTATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_ Copy of Driver’s License Expiration Date: \_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_ Copy of Auto Insurance Card Expiration Date: \_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_ Copy of CNA Certificate Expiration Date: \_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_ Copy of CPR Expiration Date: \_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_ Copy of TBST Expiration Date: \_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_ Copy of Signs and Symptoms/Chest Xray Expiration Date: \_\_\_\_\_\_\_\_\_
7. \_\_\_\_\_ Copy of Social Security Card

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOBILE PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OTHER PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF EMERGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EDUCATION:

HIGHEST GRADE COMPLETED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Nursing areas in which you have experience working: (example: Nursing Home, Hospital, Home Health, Hospice)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have experience working with Dementia, Alzheimer’s patients? YES \_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_

If yes, please explain your experience \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have experience working with Traumatic Brain Injury Patients? YES \_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_ If yes, please explain your experience \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you feel comfortable in a one-on-one environment? YES\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_

Do you feel comfortable performing activities of daily living? YES\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_

**WORK HISTORY:**

**LIST WORK HISTORY IN C N A / NA / PCA / DCW/ PCT CAPACITY ONLY PLEASE**

(Please list in order, last or current employer first)

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Salary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed From: (month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_To: (month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Salary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed From: (month/year)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_To: (month/year)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROFESSIONAL REFERENCES:**

PLEASE LIST TWO PROFESSIONAL REFERENCES IN WHICH YOU HAVE WORKED WITH OR THAT HAS SUPERVISED YOU IN THE CERTIFIED NURSE AIDE/NURSE AIDE CAPACITY.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES NO

Will you consent to a criminal background check? \_\_\_\_\_ \_\_\_\_\_

Will you consent to a drug screen? \_\_\_\_\_ \_\_\_\_\_

Have you ever been convicted of a felony crime? \_\_\_\_\_ \_\_\_\_\_

Has any disciplinary action ever been taken against your lic.? \_\_\_\_\_ \_\_\_\_\_

Have you ever been involved in a malpractice suit?  \_\_\_\_\_ \_\_\_\_\_

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EMPLOYMENT VERIFICATION RELEASE

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission for my former (current) employer

 (please print full name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Company Name and Address)

to release information concerning my employment with your facility/organization from

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Servant’s Heart Home Care, servantshearthomecare4@gmail.com

 (month/year) (month/year)

Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~**

**EMPLOYMENT CONFIRMATION TO BE COMPLETED BY EMPLOYER**

Employed from \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (month/year) (month/year)

Is/was the applicant dependable? \_\_\_\_\_\_Yes \_\_\_\_\_\_No

Does/did the applicant have a positive work performance? \_\_\_\_\_\_Yes \_\_\_\_\_\_No

Is this applicant eligible for rehire? \_\_\_\_\_\_Yes \_\_\_\_\_\_No

Reason for leaving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please check here if your company policy only allows verification of dates of employment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

We appreciate you so much for taking time to complete our form.

 Please know your reply will be considered confidential.

Please Circle the correct answer

1. A patient is confined to a hospital bed. What is the minimum amount of time patient should be turned?
2. 4 to 6 hours
3. 6 to 8 hours
4. 2 to 4 hours
5. If patient is sleeping, there is no reason to disturb them
6. The equipment you need for oral care of a patient unable to perform task independently includes:
7. Toothbrush
8. Toothpaste
9. Toothette / mouth swab.
10. All of the above
11. A patient is to be assisted out of hospital bed to sit in a wheelchair. How can this procedure be made safe?
12. Place a pillow on the wheelchair seat.
13. Place the bed in the lowest position.
14. Lower both footrest pedals
15. Release the wheel brakes.
16. When helping a client who is recovering from a stroke to walk, the aide should assist
17. On the patient’s strong side
18. With a wheelchair
19. From behind the client
20. On the client’s weak side
21. When transferring a client, MOST of the client’s weight should be supported by the aide’s
22. Wrists
23. Shoulders
24. Back
25. Legs

Please answer True or False

\_\_\_\_\_The least effective way in preventing the spread of infection is to use universal precautions.

\_\_\_\_\_Patient safety and welfare are always your first priorities.

\_\_\_\_\_It is acceptable to make yourself at home since you are not in a hospital setting

\_\_\_\_\_The main goal of proper body mechanics is to cause back injuries.

\_\_\_\_\_NPO means Nothing by mouth except water

**SKILLS CHECK LIST**

As a caregiver for Servant’s Heart Home Care, you may be expected to perform any of the following task as they are all a part of the services we may be asked to provide for our patients. Please check the skills you have experience with and feel comfortable performing.

SKILL

\_\_\_\_\_Taking vital signs

\_\_\_\_\_Placing and removing urinal

\_\_\_\_\_Placing and removing bedpan

\_\_\_\_\_Assisting patient with commode chair

\_\_\_\_\_Assisting patient with transfers

\_\_\_\_\_Assisting patient with giving a bed bath

\_\_\_\_\_Assisting patient with shampoo and mouth care

\_\_\_\_\_Assist with feeding patient

\_\_\_\_\_Assist patient with ambulation with walker and/or cane

\_\_\_\_\_Assisting patient with medicine planner

\_\_\_\_\_Assisting patient with incontinent care

\_\_\_\_\_Assisting patient with Range of motion (ROM) exercises

\_\_\_\_\_Assisting patient with Hoyer Lift

\_\_\_\_\_Assisting using a gait belt

\_\_\_\_\_Preparing meals

\_\_\_\_\_Performing light housekeeping duties

\_\_\_\_\_Running errands for patients in their personal vehicles to Dr. appt’s, grocery store, pharmacy, etc

Please explain any areas you don’t feel comfortable performing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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