Home & Hospice Care of RHODE ISLAND

Employment Application

169 George Street, Pawtucket, RI 02860
(401) 727-7070

Please Print and fill out Completely.

Date: __________________Position Applied for: ____

Name: ____
(Last) (First) (MI)

Address: ____

City: ____________________________________ State: _________________________Zip Code: ______________

Home Telephone: ( ) ______________Work Telephone: ( ) ______________ Cell Phone: ( ) _____________

Social Security Number: _____________________ May we contact you at work? ☐ Yes ☐ No

Are you a citizen of the U.S. or Alien authorized to work in the United States? ☐ Yes ☐ No
Are you at least 18 years old? ☐ Yes ☐ No

Availability: ☐ Full-time ☐ Part-time ☐ Per Diem ☐ Nights ☐ Weekends
Hours Available: ____

Education: List current or most recent first.

School Name and Address	Course of Study	Did you graduate?	Degree/Diploma

Please list other training and skills you possess.

____

____

____

Professional Licenses/Certifications	**State**	**Number**
Are you currently: Registered ☐ Licensed ☐ Certified ☐		
Are you currently: Registered ☐ Licensed ☐ Certified ☐		

Employment History: List current or most recent first. <u>Please fill in all fields completely</u>.

1) *Present or most recent employment* Company Name:	Position Title:	Dates of Employment From_______ To____
Address:	Supervisor:	May we contact? Yes___ No___ -- Current Pay Rate: $
Duties:		Reason for leaving:

2) Company Name:	Position Title:	Dates of Employment From_______ To____
Address:	Supervisor:	May we contact? Yes___ No___ -------------------------------------- Rate Paid: $
Duties:		Reason for leaving:

3) Company Name:	Position Title:	Dates of Employment From_______ To____
Address:	Supervisor:	May we contact? Yes___ No___ -------------------------------------- Rate Paid: $
Duties:		Reason for leaving:

- Is there any reason why you cannot perform the essential functions of the position for which you are applying? ☐ Yes ☐ No If Yes, explain: ____
- Do you have a valid driver's license? ☐ Yes ☐ No Which State? _______________
- Do you have a car available for travel? ☐ Yes ☐ No
- Can you provide proof of auto insurance? ☐ Yes ☐ No
- Rhode Island law requires employees of home health agencies are subject to a criminal background check. Would you be opposed to such a check? ☐ Yes ☐ No
- Have you been convicted or a felony? ☐ Yes ☐ No

Are you currently, or have you ever been, or has the government proposed that you be, excluded from participation in federal health care programs (e.g. Medicare, Medicaid)? If yes, please describe the circumstances and indicate the period of exclusion:

____
____

How did you hear about HHCRI and the position? ____

References: List 3 references who can evaluate your work. Also, list how they are known to you.

PLEASE DO NOT LIST ANYONE RELATED TO YOU OR FRIENDS. ONE MUST BE A SUPERVISOR.

Name	How do you know them?	Address/Telephone Number

Were you ever previously employed by Home & Hospice Care of Rhode Island formerly known as Hospice Care of Rhode Island? ☐ Yes ☐ No

If so, Dates of Employment: ____________to____________. Position Held: ________________________

Do you have any friends or relatives working here? ☐ Yes ☐ No

If yes, please give name and relationship____

I hereby affirm that the information given 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 from further consideration for employment and may result in discharge if discovered at a later date. If I am released under these conditions, I will be paid only through the day of release and my employer has the right to cancel any benefits that I may have accrued.

I understand that acceptance of an offer of employment does not create a contractual obligation to continue to employ me in the future.

Signature: ____
Date: __________________________

It is the policy of Home & Hospice Care of Rhode Island to check references offered by applicants. It is our objective to obtain information on ability, previous job performance, character and reputation for the sole purpose of considering you for employment.

I hereby give Home & Hospice Care of Rhode Island permission to request and obtain such information.

Signature: ____
Date: __________________________

Self – Identification Applicant Form

(Please note this form will be kept separate from the application. It is considered confidential and not used in any hiring decision)

Anti-Discrimination Notice. It is an unlawful employment practice for an employer to fail or refuse to hire or discharge any individual, or otherwise to discriminate against any individual with respect to that individual's terms and conditions of employment, because of such individual's race, color, religion, sex, or national origin.

This employer is subject to certain nondiscrimination and affirmative action recordkeeping and reporting requirements which require the employer to invite employees to voluntarily self-identify their race/ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable federal laws, executive orders, and regulations, including those which require the information to be summarized and reported to the Federal Government for civil rights enforcement purposes.

If you choose not to self-identify your race/ethnicity at this time, the federal government requires this employer to determine this information by visual survey and/or other available information. All information will be reported in the same six race/ethnicity categories identified below.

Section 1: General Applicant Information

Name:	Date:
Position Applied for:	Gender:
	☐ Male ☐ Female

Referral Source

☐ Walk-In ☐ Government Employment Agency ☐ Private Employment Agency ☐ School ☐ Job Fair

☐ Employee ☐ Relative ☐ Advertisement ☐ Other ______________________________

INVITATION TO SELF-IDENTIFY
PLEASE ANSWER THE FOLLOWING QUESTION

What is your race/ethnicity? You may mark only one box.

☐ White ☐ Black/African American (not of Hispanic Origin) ☐ Hispanic/Latino

☐ Asian ☐ Native Hawaiian or other Pacific Islander

☐ American Indian/Alaska Native ☐ Two or more races

To Vietnam Ear Veterans, Disabled Veterans and Individuals with physical or mental disabilities:

Government contractors subject to Vietnam Ear Veterans Readjustment Act of 1974 and the Rehabilitation Act of 1973 are required to take affirmative action to employ and advance in employment qualified disabled veterans, veterans of the Vietnam Era and qualified handicapped individuals.

You are invited to volunteer this information, if you qualify, to assist in proper placement and determining reasonable accommodation. This information will be considered confidential. Refusal to provide this information will not adversely affect your consideration for employment.

If you wish to be identified, please check if any of the following are applicable:

☐ Vietnam Era Veteran/served between 1964-1975 ☐ Disabled Veteran
☐ Other Eligible Veteran ☐ Individual with a disability