Employment Application

Applicant Information

Full Name: _____ Date: _____

Last *First* *M.I.*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone: **( )** E-mail Address:

Date Available: Social Security No.: Desired Salary: **$**

Position Applied for:

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If yes, when?

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain:

Education

High School: Address:

From: To: Did you graduate? YES ☐ NO ☐ Degree:

College: Address:

From: To: Did you graduate? YES ☐ NO ☐ Degree:

Other: Address:

From: To: Did you graduate? YES ☐ NO ☐ Degree:

Military Service

Branch: From: To:

Rank at Discharge: Type of Discharge:

If other than honorable, explain:

Previous Employment

Company: Phone: ( )

Address: Supervisor:

Job Title: Starting Salary: **$** Ending Salary: **$**

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: Phone: ( )

Address: Supervisor:

Job Title: Starting Salary: **$** Ending Salary: **$**

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: Phone: ( )

Address: Supervisor:

Job Title: Starting Salary: **$** Ending Salary: **$**

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: ______________________________ Date: ______________

PRE EMPLOYEMENT INQUIRY AUTHORIZATION AND RELEASE

Applicant Instruction
Please complete Section 1 and return this Release to Advantage Private Home Care with your application for employment. Please select the most recent employer from employment application.

Section 1: Please clearly print or type all information

Last Name:	First Name	
Previous Employer:	Previous Employer Address:	
City:	State	Zip Code:
Supervisor's Name:	Supervisor's Title	
Telephone Number	Fax Number	

In connection with my application for employment, I understand and agree that Advantage Private Home Care will seek information as to my character, work habits, job performance, skills, and abilities, I authorize my previous employer, referenced above, to release any and all information relating to my employment

Applicant Signature_____ Date _____/_____/_____

Section 2: To be completed by the applicant's previous employer

Dear Employer

The above-named applicant is seeking employment with Advantage Private Home Care and has listed your organization as a former place of employment in accordance with the release signed by the applicant, please provide the information requested below. We appreciate your cooperation with providing the information below and answering the following questions. Your responses will be held in the strictest of confidence and will not be released to the applicant. Thank you in advance for your assistance.

- Position (s) Held by Applicant: _____
- Dates of Employment From: _____To: _____
- Is Applicant Eligible for rehire? _____YES _____NO
- Reason for Separation: ____Voluntary Resignation___Termination___Temporary/Seasonal___Other

	Superior	Exceeds Standards	Meets Standards	Does Not Meet Standards
Quality of Work Performed				
Professionalism				
Communication Skills				
Adherence to policies &				
Establishes Priorities				
Ability to Relate to Patients				
Ability to Relate to Staff				
Ability to Handle Stress				
Adaptability to Change				
Quality of Clinical Documentation				
Attendance/Punctuality				

Person Providing the above information: _____ Date: ___/___/_____

Advantage Private Home Care Rep: _____Date: ___/___/_____

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Quality of Clinical Documentation				
Attendance/Punctuality				

Person Providing the above information: _____ Date: ___/___/_____

Advantage Private Home Care Rep: _____Date: ___/___/_____

CITY OF CHAMBLEE POLICE
Donny Williams, Police Chief

CITY OF CHAMBLEE

3518 BROAD STREET CHAMBLEE, GA 30341

CHAMBLEE POLICE DEPARTMENT
CRIMINAL HISTORY CONSENT FORM

I hereby authorize Advantage Private Home Care
to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

_____
Full Name (print)

_____
Address

_____ _____ _____ _____
Sex Race Date of Birth Social Security Number

_____
Signature

_____
Date

Special employment provisions (check if applicable):
☒ Employment with mentally disabled (Purpose code 'M')
☒ Employment with elder care (Purpose code 'N')
☒ Employment with children (Purpose code 'W')

One of the following must be checked:
☐ This authorization is valid for 90/180/_____ (circle one) days from date of signature.
☒ I, _____, give consent to the above named to perform periodic criminal history background checks for the duration of my employment with this company.
☐ This authorization is valid for one (1) time only from the date you have entered.

CH CLERK: _____ DATE: _____

CORPORATE PAYROLL SERVICES

Authorization Agreement For Direct Deposit Employees

For direct deposit employees, this Authorization Agreement along with voided check(s) or deposit ticket(s) must be received a minimum of 5 banking days before the first direct deposit pay date. This Authorization Agreement may be initially faxed along with a copy of voided check(s) or deposit ticket(s) to CPS. Originals must be received by us within 5 business days.

Employee Name _____ Employee ID #_____

Company Name ___Advantage Private Home Care_____ Cust. ID #____LEVYHC_____

Corporate Payroll Services cannot set up direct deposits for "credit only" accounts. These accounts do not allow debit entries, which are necessary for voiding and reissuing checks.

Corporate Payroll Services does not offer direct deposit of funds to either a foreign bank or a U.S. Financial institution where the entire amount will be forwarded to a bank account in another country. If either situation applies to you, do not complete this form.

If you only have one account, simply write 100 next to the % sign in the first row. You may choose up to 4 accounts into which your net pay is deposited. Please enter either a dollar amount or a percentage for all accounts. If you choose the Dollar method, all remaining amounts will be directed to the first account listed below. If using the Percentage method, the total of the percentages must equal 100%.

$ All Remaining **OR** _____**%** * Bank Name_____ Checking☐ Savings☐

Routing_____ Acct#_____

$_____.____ **OR** _____**%** * Bank Name_____ Checking☐ Savings☐

Routing_____ Acct#_____

$_____.____ **OR** _____**%** * Bank Name_____ Checking☐ Savings☐

Routing_____ Acct#_____

$_____.____ **OR** _____**%** * Bank Name_____ Checking☐ Savings☐

Routing_____ Acct#_____

* Total for **ALL %** amounts must = 100

I hereby authorize Corporate Payroll Services, its agents and the bank named above to initiate credit and any necessary adjusting debit entries to my account(s) indicated above. This Authority is to remain in effect until Corporate Payroll Services and the bank have received written notice from me of its termination in such time and manner as to afford Corporate Payroll Services and the bank a reasonable opportunity to act on it.

Signature_____ Date ____/_____/_____

***Please email my direct deposit stub to** :_____

Staple copy of voided check(s) to this form when sending originals

For office use only: Entered by _____ Date _____ Email entered? Y N Notes: _____

Verified by _____ Date _____ Email verified? Y N Notes: _____

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

ACKNOWLEDGEMENT OF APPLICANT'S NON-CRIMINAL JUSTICE PRIVACY RIGHTS AND CONSENT TO BE INCLUDED IN THE CAREGIVER PORTAL

SECTION I – PRIVACY RIGHTS - TO BE COMPLETED BY INDIVIDUAL BEING FINGERPRINTED:

APPLICANT TYPE:
- ☐ Owner (Facility)
- ☐ Applicant for Employment/Direct Access Employee (Facility)
- ☐ Non-Employee (Facility Volunteer)
- ☐ Contractor/Direct Access (Facility)

PRINT FULL NAME _____ (Last) _____ (First) _____ (Middle) _____ (Date of Birth (mm/dd/yyyy))

Home Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

_____ (Email Address) _____ (Telephone No.)

Advantage Private Home Care
Name of Facility

5825 Glenridge Drive, Bldg 4, Suite 101 (Street) | Atlanta (City) | GA (State) | 30328 (Zip)

I hereby authorize the Georgia Department of Community Health (DCH), Office of Inspector General, to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia. I understand a State and Federal fingerprint criminal background check will be conducted. By signing below, I am indicating that I have read and understand the terms and conditions of the attached Non-Criminal Justice Applicant's Privacy Rights and Policy Act Statements.

_____ Applicant Signature _____ Date

SECTION II – CAREGIVER PORTAL - TO BE COMPLETED ONLY BY AN APPLICANT OR EMPLOYEE BEING FINGERPRINTED AS PART OF FACILITY LICENSURE. DOES NOT INCLUDE OWNERS OR FAMILY EMPLOYERS.

APPLICANT TYPE
- ☑ Applicant for Employment/Direct Access Employee (Licensed Facility)
- ☐ Non-Employee (Volunteer at Licensed Facility)
- ☐ Contractor/Direct Access Employee (Licensed Facility)

The Georgia Caregiver Portal only contains the eligibility status of applicants and employees who have successfully passed the background screening process. The Caregiver Portal does not contain the names of applicants and employees who are ineligible. Family employers can access the Caregiver Portal to view a prospective applicant or current employee's eligibility to determine their suitability for employment to provide personal care services to that employer's elderly family member or wards. All services are performed at locations not licensed by DCH. Individuals should check one of the boxes below.

☑ I **agree** to the results of my background check determination being available to family employers in the Georgia Caregiver Portal.

☐ I am seeking employment only by licensed healthcare employers. I **do not want or agree** to the results of my background check determination being available to family employers.

_____ Applicant Signature _____ Date

Georgia Department of Driver Services
Customer Service, Licensing and Records Division
P.O. Box 80447
Conyers, Georgia 30013

REQUEST FOR MOTOR VEHICLE REPORT (MVR)

☐ **I am requesting my own Georgia MVR. (Complete Sections 1, 3, and 4)**

☐ **I am requesting a Georgia MVR of another individual. (Complete Sections 1, 2, 3, and 4)**

PLEASE PRINT LEGIBLY

SECTION 1 – DRIVER INFORMATION (must exactly match driving record)			
Full Name (First, Middle, Last)			
Driver Date of Birth (MM/DD/YY)		**Driver's License Number**	

SECTION 2 – THIRD PARTY REQUESTOR INFORMATION	
Full Name (First, Middle, Last)	
Firm Name (if applicable)	
Address	
FOR DEPARTMENTAL USE ONLY	

SECTION 3 – TERM OF REQUEST

Please choose one of the following options:

☐ **Three (3) year Georgia MVR ($6.00 fee)**

☐ **Seven (7) year Georgia MVR ($8.00 fee)**

☐ **Lifetime Georgia MVR ($8.00 fee)**

If you are requesting a Georgia MVR by mail, please include a business sized self-addressed stamped envelope along with this request and the required payment amount. By mail, we accept personal checks, cashier's checks, money orders, and company checks.

SECTION 4 – AUTHORIZATION TO RELEASE RECORD OF DRIVER

Under penalty of law, I hereby (Please check one)

☐ **request release of my driving record; OR**

☐ **consent to release of my driving record to the person and/or entity named in Section 2, in accordance with O.C.G.A. §40-5-2.**

Signature of Driver		**Date (MM-DD-YY)**	