MEMORANDUM

To: Care Providers

From: EldersChoice Human Resources

Re: Application for Registration

Thank you for your interest in EldersChoice. The pages that follow are an application to be registered as a care provider with EldersChoice in Connecticut, Maryland and Pennsylvania. We are in the business to arrange for the placement of full-time live-in home-care professionals (Care Providers) who work as independent contractors to provide home-care for individuals who need support personal care, homemaking and companionship in their place of residence or other living environment. EldersChoice only places full-time live-in care providers.

Care Providers must meet EldersChoice standards. This includes being legal to work in the United States, have training and experience, and be healthy. The Application includes a checklist of all the information we need from you. An interview is required after a file is complete. Then we complete our Referral Agreement and you are eligible for referral.

Being registered means that you want EldersChoice to present possible client opportunities (cases) to you. You have the right to pursue or decline any client opportunity. You do not have to use EldersChoice to find clients. A Care Provider can accept a placement from any person and use other agencies to find clients.

As the Care Provider, you are paid directly by the client. You never pay EldersChoice for placement services. Care Providers are independent contractors and not employees of EldersChoice for all purposes, including federal, state and local taxes. The services you provide, hours, and pay are entirely between you and the referred Client. Any changes to fees, work schedule, and time off is between you and the referred Client. EldersChoice has no right to tell the client what to do, terminate, interfere or impose any terms or conditions on your relationship with the client.

EldersChoice is an equal opportunity organization. EldersChoice does not discriminate in referrals on the basis of race, sex, color or national origin, age, ancestry, religious creed, sexual orientation, and handicap or disability.

PLEASE FILL OUT THE APPLICATION AND FOLLOW

THE MAILING or FAX INSTRUCTIONS ON THE NEXT PAGE

 EldersChoice Incorporated

DOCUMENT CHECKLIST FOR REGISTRATION

<u>Please send COPIES of the following to EldersChoice:</u>

- ☐ Care Provider Registration Form
- ☐ United States Passport, Naturalization Certificate, Permanent Resident Card, or Work Authorization.
- ☐ Social Security Card
- ☐ Proof of Training or License (CNA/HHA/PCA/STNA)
- ☐ Certification of Elder Abuse Training [*CONNECTICUT only*.] Free online at https://portaldir.ct.gov/dss/learncenter/elderabuse/mand/story_html5.html
- ☐ Driver's license or Non-Driver's picture Identification
- ☐ Health form with results of a physical performed within the last 24 months signed and stamped by your doctor or other licensed health professional. You do not have to use EldersChoice form if you already have one from your doctor.
- ☐ PPD Form showing proof of a negative two step Mantoux test or chest x-ray within the last two years. You do not have to use EldersChoice form if you already have one from your doctor.
- ☐ Authorizations for Criminal Background Checks in Connecticut, Maryland and Pennsylvania.
- ☐ Work Reference sheets provided. **<u>SIGN ONLY.</u>** EldersChoice will use the space to document your work from two previous employers. EldersChoice only accepts references from hospitals, nursing homes, rehabilitation facilities, nursing and hospice agencies, other home care agencies, group homes or private cases.

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED & DESTROYED IN 30 DAYS

Please Mail or Fax this Registration Application to *<u>ONE</u>* of the Locations Below.

EldersChoice. Inc.	EldersChoice of Maryland, LLC	EldersChoice of Connecticut, LLC
P.O. Box 61122	3681 Ashley Way	P.O. Box 370361
Harrisburg, PA 17106-1122	Owings Mills, MD 21117-1435	West Hartford, CT 06137-0361
Fax: 717-541-8295	Fax: 410-363-6795	Fax: 860.523.8400

CARE PROVIDER REGISTRATION/INFORMATION

Name: ____

Current Address:____

Years at this Address: ____ Prior Address: ____

____

Phone: (_____) _________________ ☐ Cell   Phone: (_____) _______________ ☐ Home

Date of Birth (mm/dd/yyyy): _____________Email Address: ___________________________

Social Security Number: ______________________   EIN Number: _______________________
(Please provide copy of Social Security Card)

Passport, Green card or Long Term Visa Number:______________________________________
(Please provide copy of passport or Green Card)

Work Permit? Yes☐   No☐ Expires: ______________ **(Please provide copy of Work Permit)**

Driver's License: State: _______   Number: _________________________
(Please provide copy of Driver's License)

RECENT WORK EXPERIENCE/REFERENCES:

1. Name of Client or Business:____

Address:____

State and Zip Code:_______________________________   Telephone:_________________

How long did you work there?_______________________________

2. Name of Client or Business:____

Address:____

State and Zip Code:_______________________________   Telephone:_________________

How long did you work there?_____________________________

PROFESSIONAL EDUCATION AND TRAINING:

High School: ________________________________ City/State: _________________________

Dates Attended: ____________________________________

College: ________________________________ City/State: _____________________________

Dates Attended: _____________________________ Degree Earned: ______________________

Trade School/Other: ________ ___________________ City/State: _______________________

Dates Attended: _____________________________ Degree Earned: ______________________

TRAINING OR LICENSE

(Please provide copy of Graduation Certificate or License):

☐ CNA Date Earned ________ State ____

☐ HHA Date Earned ________ State ____

☐ Other ________ Date Earned ________ State ____

Special skills or training: ____

____

Date you are available to start work _______________________

Range of fees you charge: from $ __________ per day – up to – $ ___________ per day

Are you registered with other home care agencies? Yes☐ No☐

Agency Names: ____

Locations you want to work? **(check all that apply)** ☐ CT ☐ MD ☐ PA

Any restrictions on what you can do? ____

____

Other information about the kinds of clients you are seeking (e.g., no family living in home): __________

____

Live in House with Pets? Yes☐ No☐ Live with client and family members? Yes ☐ No ☐

Live-in house with smoker? Yes☐ No☐

I certify that the statements made by me on this application are true and complete to the best of my knowledge and are made in good faith. I understand that if I knowingly make any misstatements of fact, I am subject to disqualification, dismissal, or other action pursuant to employment agency policy and procedure, and subject to criminal penalties as prescribed by law. I understand that I am responsible for keeping EldersChoice informed of any changes to my registration information. I also authorize EldersChoice to verify the information contained in this document including, but not limited, to contacting previous employers/clients and references. I authorize all persons and companies listed herein to disclose any information concerning my background, and hereby release such parties from any liability or damages resulting from providing such information.

Signature: ____ Date: _______________

Printed Name: ____

CARE PROVIDER HEALTH FORM

[You can use your own form]

HEALTH HISTORY ***(the top portion to be completed by Care Provider)***

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Shortness of Breath	☐	☐	Hospitalized
☐	☐	Heart Disease	☐	☐	Epilepsy/Seizures	☐	☐	Mental Disorder
☐	☐	Hepatitis A	☐	☐	Hepatitis B	☐	☐	Asthma
☐	☐	Stroke	☐	☐	Back/Spinal Problems	☐	☐	Salmonella
☐	☐	Shigella	☐	☐	COVID-19	☐	☐	HIV

If you answered YES to ANY of the questions about, please explain: ____________________
____

Do you have any other conditions which might cause risk to a client or could potentially interfere with the performance of one's duties, including the habituation of alcohol or current addiction to depressants, stimulants, narcotics, or any other substances? ☐ NO ☐ YES Please explain ____
____

I certify that the statements made by me on this application are true and complete to the best of my knowledge and are made in good faith. I understand that if I knowingly make any misstatements of fact, I am subject to disqualification, dismissal, or other action pursuant to employment agency policy and procedure, and subject to criminal penalties as prescribed by law.

____ ________________________
Care Provider Signature Date

CARE PROVIDER HEALTH EXAMINATION

TO BE COMPLETED, SIGNED, DATED AND STAMPED BY PHYSCIAN

Blood Pressure___________ T______ P______ R______ Height______ Weight_____
Ears _____ Abdomen _____ Hernia_____ GI History________________________
Eyes _____ Skin _____ Heart _____ GU History ______________________
Nose_____ Throat _____ Lungs_____ Extremities ______________________

Patient is found to be in good health without evidence of communicable disease or work restrictions except as noted: ____.
____

____ _______________
Physician/PA/APRN/Nurse Practitioner . Date

EldersChoice Incorporated

PPD FORM

[You can use your own form]

All Newly Registered Care Providers MUST Have Proof of a Negative 2 Step PPD or Chest X-Ray

Section I: [To be completed by Care Provider]

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

Social Security Number:______________________ Telephone: ________________________

Section II: [To be completed by Health Care Professional]

____
Provider Name and Title

____
Provider Address

Tuberculosis Screening (PPD) – Step 1		**Tuberculosis Screening (PPD) – Step 2**	
Date Given:	**Time:**	**Date Given:**	**Time:**
Manufacturer:		**Manufacturer:**	
Lot:	**Exp. Date**	**Lot:**	**Exp. Date:**
Dosage:	**Route:**	**Dosage:**	**Route:**
Arm: (circle one) L R		**Arm: (circle one) L R**	
Signature:		**Signature:**	

Section III: [To be completed if 10mm or greater]

1. Attach copy of Chest X-ray report.
2. Is patient free of infectious Tuberculosis Disease? ☐ Y ☐ N
3. Was patient referred for treatment? ☐ Y ☐ N
   If Yes, When, Where and What is treatment ____________________________________
   ____
4. Was BCG given? ☐ Y ☐ N
   If Yes, when was it given? ____

EldersChoice Incorporated

CARE PROVIDER REFERENCES

PLEASE ONLY SIGN AND DATE THIS FORM

Care Provider Name:____

SSN:_______-_____-_______

Employer/Client: ____

Job Description:____

Please list start and end date of employment: ____________to_____________

Is ________________________________ eligible for rehire? ☐ Yes ☐ No

Comments if possible:

____

____

____

____

____

____

____

____

____

____

I give EldersChoice permission to check my previous employment references.

_____________________________________ _____________________

Signature of Care Provider Date

Print Name ____________________________________

Authorization for Submission of Criminal Background Check - CT

In accordance with Chapter 400o, Section 20-678 of the Connecticut General Statutes, Homemaker and Companion Agencies are required to conduct a comprehensive background check of all care providers. In addition, prospective care providers are required to reply to the following questions:

1. Have you ever been convicted of a crime involving violence or dishonesty in a state court or federal court in any state? ☐ Yes ☐ No

2. Have you ever been subject to any decision imposing disciplinary action by a licensing agency in any state, the District of Columbia, a United States possession or territory or a foreign jurisdiction? ☐ Yes ☐ No

EldersChoice will not refer any care provider who has a history of elder abuse or criminal background.

I hereby certify that the statements made by me on this application are true and complete to the best of my knowledge and are made in good faith. Further, I authorize EldersChoice of Connecticut, LLC to conduct a comprehensive background check. I understand that if I knowingly make any misstatements of fact, I am subject to disqualification and dismissal and to such other penalties as may be prescribed by law or EldersChoice policy and procedure.

As sworn by me this ____________ day of _____________________ 20 ____

_____________________________________ _______________________________

Signature of Care Provider Print Name

_____________________________________ _______________________________

Signature of Witness Print Name

Authorization for Submission of Criminal Background Check - MD

In accordance with Health - General Article Title 19, Subtitle 4B, Article 03(c) under the Annotated Code of Maryland, EldersChoice is required to perform a state criminal history records check or a private agency background check.

EldersChoice will neither refer nor contract with an individual who has a history of elder abuse or criminal background.

In signing below, you are attesting that you have not been convicted of any crime in your lifetime. In addition, your signature below serves as your permission to submit your name to be submitted for a State criminal history records check or a private agency background check.

___________________________________ ______________________

Signature Date

 EldersChoice Incorporated

Authorization for Submission of Criminal Background Check - PA

The Older Adults Protection Service Act of Pennsylvania Act 13 and Act 14 prohibits hiring of individuals to a skilled Nursing Facility, Personal Care Home, Home Health Agency or enrolling in a Nurse Aide training program who have in their lifetime been convicted of one of the following crimes:

* Aggravated Assault
* Burglary
* Concealing the death of a child
* Endangering the welfare of children
* Felony theft or 2 or more misdemeanor thefts
* Indecent Assault
* Intimidation of victim or witness
* Involuntary Deviate Sexual Intercourse performances
* Retaliation against Victim or Witness
* Securing the execution of documents by
* Deception
* Sexual Abuse of Children
* Arson
* Criminal Homicide
* Dealing in infant death
* Forgery
* Incest
* Kidnapping
* Indecent Exposure
* Murder
* Rape & Sexual Assault
* Robbery
* Sexual Assault
* Organized Retail Theft
* Unlawful Restraint

In signing below, you are attesting that you have not been convicted of any crime listed above in your lifetime. In addition, your signature below serves as your permission to permit your name to be submitted to the Pennsylvania State Police Criminal Background Check System* and/or background check through the FBI.

<u>Proof of Residency</u>: EldersChoice, Inc. will request that a Direct Care Worker submit proof of residency through the submission of the following documents:

- ☐ **Valid state driver's license or a State-issued identification**
- ☐ **Housing records, such as a mortgage or rent receipts**
- ☐ **Public utility records such as an electric bill, local tax records**
- ☐ **Federal, State or local income tax return with the applicant's name and address preprinted on it or employment record.**

<u>Please answer the following questions:</u>

PRINT Name: ______________________ ____________ ____
First Middle Last

Current Address: ____

If you live in Pennsylvania, have you lived here for two consecutive years? ☐ Yes ☐ No

Valid driver's license or state-issued identification card:
State ________ License #___________________________ Valid thru (Expires): ______________________

Signature: ____ Date:____________________