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–carefor 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

DOCUMENT CHECKLIST FOR REGISTRATION

Please send COPIES of the following to EldersChoice:

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. SIGN ONLY. 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 ONE of the Locations Below.

EldersChoice of Maryland, LLC	EldersChoice of Connecticut, LLC
3681 Ashley Way	P.O. Box 370361
Owings Mills, MD 21117-1435	West Hartford, CT 06137-0361
Fax: 410-363-6795	Fax: 860.523.8400

CARE PROVIDER REGISTRATION/INFORMATION

Name:_____

CurrentAddress:_____

YearsatthisAddress:____PriorAddress:_____

_____

Phone:(____) _____ Cell Phone:(____) _____ Home

Dateof Birth (mm/dd/yyyy):_____Email Address:_____

SocialSecurityNumber:_____ EIN Number:_____
(Please provide copy of Social Security Card)

Passport,Greencardor LongTermVisaNumber:_____
(Please provide copy of passport or Green Card)

Work Permit? Yes No Expires:_____ (Please provide copy of Work Permit)

Driver'sLicense: State:_____ Number:_____
(Please provide copy of Driver's License)

RECENT WORK EXPERIENCE/REFERENCES:

1. NameofClientorBusiness:_____

Address:_____

StateandZipCode:_____ Telephone:_____

Howlongdidyouworkthere?_____

2. NameofClientorBusiness:_____

Address:_____

StateandZipCode:_____ Telephone:_____

Howlongdidyouworkthere?_____

PROFESSIONAL EDUCATION AND TRAINING:

HighSchool:_____ City/State:_____

DatesAttended:_____

College:_____ City/State:_____

DatesAttended:_____ DegreeEarned:_____

TradeSchool/Other:_____ City/State:_____

DatesAttended:_____ DegreeEarned:_____

TRAINING OR LICENSE

(Please provide copy of Graduation Certificate or License):

CNA	Date Earned_____	State ___
HHA	Date Earned_____	State ___
Other_____	Date Earned_____	State ___

Specialskillsortraining:_____

_____

Date you are available to start work _____

Rangeof fees you charge: from $ _____ per day – up to – $ _____ per day

Are you registered with other home care agencies? Yes No

AgencyNames:_____

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

Anyrestrictionsonwhatyoucando?_____

_____

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:_____

PrintedName:_____

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

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:

SocialSecurityNumber:_____ 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 10mmor greater]

1. Attach copy of Chest X–rayreport.
2. Is patient free of infectious Tuberculosis Disease? Y N
3. Was patient referred for treatment? Y N
   If Yes,When,Where andWhat is treatment_____
   _____
4. Was BCG given? Y N
   If Yes,whenwasit given? _____

CARE PROVIDER REFERENCES

PLEASE ONLY SIGN AND DATE THIS FORM

CareProviderName:_____

SSN:_____–____–_____

Employer/Client:_____

Job Description:_____

Please list start and end date of employment:_____to_____

Is _____ eligibleforrehire? Yes No

Comments if possible:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I give EldersChoice permission to check my previous employment references.

_____ _____

Signature of Care Provider Date

PrintName_____

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.

Assworn 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

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.

Proof of Residency: 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.

Please answer the following questions:

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#_____ Validthru (Expires):_____

Signature:_____ Date:_____