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 and Maryland. 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 homecare 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 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 CHECK LIST FOR REGISTRATION

Please send COPIES of the following to EldersChoice:

1. United States Passport, Naturalization Certificate, Permanent Resident Card, or Work Authorization.
2. Social Security Card.
3. Proof of Training or License (CNA/HHA/PCA/STNA)
4. Certification of Elder Abuse Training [CONNECTICUT only.] Free online at https://portaldir.ct.gov/dss/learncenter/elderabuse/mand/story_html5.html
5. Driver's license or Non-Driver's picture Identification.
6. 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.
7. 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.
8. Authorizations for Criminal Background Checks in Connecticut and Maryland.
9. 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 & DESTROYEDIN 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: _____

Current Address: _____

Years at this Address: _____ Prior Address: _____

Phone: _____ Cell Phone: _____

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:

Name of Client or Business: _____

Address: _____

State and Zip Code: _____ Telephone: _____

How long did you work there? _____

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 YES ☐ NO ☐	Date Earned	State
HHA YES ☐ NO ☐	Date Earned	State
Other YES ☐ NO ☐	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 homecare agencies? YES ☐ NO ☐

Agency Names: _____

Locations you want to work. (Check all that apply) CT ☐ MD ☐

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 above, 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? YES ☐ NO ☐
If 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.

Signature: _____ Date: _____

Care Provider Signature

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:

Signature: _____ Date: _____

Physician/PA/APRN/Nurse Practitioner Signature

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 Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Telephone: _____

Section II:

(To be completed by Health Care Professional)

Provider Name: _____ Title: _____

Provider Address: _____

Tuberculosis Screening (PPD) – Step 1		**Tuberculosis Screening (PPD) – Step 2**	
Date Given	Time	Date Given	Time
Manufacturer		Manufacturer	
Lot	Lot	Exp Date	Exp Date
Dosage	Dosage	Route	Route
Arm (Circle one)	Left Right	Arm (Circle one)	Left Right
Signature		Signature	

Section III:

(To be completed if 10mmor greater)

1. Attach copy of Chest X-ray report.
2. Is patient free of infectious Tuberculosis Disease? YES ☐ NO ☐
3. Was patient referred for treatment? YES ☐ NO ☐

   If YES, when: _____

   Where: _____

   What is treatment: _____
4. Was BCG given? YES ☐ NO ☐

   If YES, when was it given? _____

CARE PROVIDER REFERENCES

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: _____ Date: _____

Care Provider Signature

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:

Have you ever been convicted of a crime involving violence or dishonesty in a state court or federal court in any state? YES ☐ NO ☐

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: _____ Date: _____

Care Provider Signature

Print Name: _____

Signature: _____ Date: _____

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 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: _____

Care Provider Signature