

Employment Application

Applicant Information

Full Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit#

City State Zip Code

Phone: _____ Email: _____

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? If yes, when? _____

Have you ever been convicted of a felony?

If yes, explain: _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES NO Diploma: _____

College: _____ Address: _____

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

Other: _____ Address: _____

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

References

Please list three professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

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

Military Service

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: _____

If other than honorable, explain: _____

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.

Print Name: _____

Signature: _____ Date: _____



agency for persons with disabilities
State of Florida

ATTESTATION OF GOOD MORAL CHARACTER

Employee/Applicant/Contractor/Volunteer Name:

By signing this form, I affirm and attest that I meet the Moral Character requirements for employment as required pursuant to Chapter 435, Florida Statutes, and Section 393.0655, Florida Statutes.

Provider/Employer Name:

I have not been arrested with disposition pending or found guilty of regardless of adjudication, or entered a plea of nolo contendere (no contest) to or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under any of the following provisions of the Florida statutes or under any similar statute of another jurisdiction for any of the offenses listed below.

Criminal Offenses listed in section 435.04, F.S.

- (a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- (b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- (c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- (d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (e) Section 782.04, relating to murder.
- (f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.
- (g) Section 782.071, relating to vehicular homicide.
- (h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.
- (i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.
- (j) Section 784.011, relating to assault, if the victim of the offense was a minor.
- (k) Section 784.03, relating to battery, if the victim of the offense was a minor.
- (l) Section 787.01, relating to kidnapping.
- (m) Section 787.02, relating to false imprisonment.
- (n) Section 787.025, relating to luring or enticing a child.
- (o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.
- (p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.
- (q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.
- (r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.
- (s) Section 794.011, relating to sexual battery.
- (t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
- (u) Section 794.05, relating to unlawful sexual activity with certain minors.
- (v) Chapter 796, relating to prostitution.
- (w) Section 798.02, relating to lewd and lascivious behavior.
- (x) Chapter 800, relating to lewdness and indecent exposure.
- (y) Section 806.01, relating to arson.
- (z) Section 810.02, relating to burglary.

- (aa) Section 810.14, relating to voyeurism, if the offense is a felony.
- (bb) Section 810.145, relating to video voyeurism, if the offense is a felony.
- (cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.
- (dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.
- (ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.
- (ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.
- (gg) Section 825.103, relating to felony offenses for the exploitation of an elderly person or disabled adult.
- (hh) Section 826.04, relating to incest.
- (ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.
- (jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.
- (kk) Former s. 827.05, relating to negligent treatment of children.
- (ll) Section 827.071, relating to sexual performance by a child.
- (mm) Section 843.01, relating to resisting arrest with violence.
- (nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.
- (oo) Section 843.12, relating to aiding in an escape.
- (pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institution.
- (qq) Chapter 847, relating to obscene literature.
- (rr) Section 874.05, relating to encouraging or recruiting another to join a criminal gang.
- (ss) Chapter 893, relating to drug abuse prevention and control if the offense was a felony or if any other person involved in the offense was a minor.
- (tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting requirements for such sexual misconduct.
- (uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.
- (vv) Section 944.40, relating to escape.
- (ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.
- (xx) Section 944.47, relating to introduction of contraband into a state correctional facility.
- (yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.
- (zz) Section 985.711, relating to contraband introduced into detention facilities

435.04(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Section 393.0674(2), felony offenses for the release or use of information from juvenile records of the Agency for Persons with Disabilities for any purpose other than screening for employment

Criminal Offenses listed in section 393.0655 (5), F.S.

- (a) Any authorizing statutes, if the offense was a felony.
- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (f) Section 817.234, relating to false and fraudulent insurance claims.
- (g) Section 817.505, relating to patient brokering.
- (h) Section 817.568, relating to criminal use of personal identification information.
- (i) Section 817.60, relating to obtaining a credit card through fraudulent means.
- (j) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (k) Section 831.01, relating to forgery.
- (l) Section 831.02, relating to uttering forged instruments.
- (m) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (n) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

The following acknowledgements apply to all Direct Service Providers and/or Employees, Contract Providers, and Volunteers. Please initial each statement.

- _____ I affirm that I have not be designated as a sexual predator pursuant to s. 775.21; a career offender pursuant to s. 775.261; or a sexual offender pursuant to s. 943.0435, unless the requirement to register as a sexual offender has been removed pursuant to s. 943.04354.
- _____ I understand that I must acknowledge the existence of any applicable criminal record relating to the above lists of offenses including those under any similar statue of another jurisdiction, regardless of whether or not those records have been sealed or expunged.
- _____ I understand that, while employed or volunteering in any position that requires an APD background screening as a condition of employment, I must immediately notify my supervisor/employer of any arrest, any notice of possible criminal prosecution including any violation or infraction mandating a court appearance. Reporting must be done immediately if during normal working hours or immediately the next business day if after normal working hours.

ONE OF THE FOLLOWING MUST BE SIGNED:

I attest that I have read the above carefully and state that my attestation here is true and correct and that my record does not contain any of the above listed offenses. I understand, under penalty of perjury, at employees in such positions of trust or responsibility shall attest to meeting the requirements to the background screening standards set forth in Chapter 435 and Section 393.06555.

Signature of Affidavit

Date

OR

My record contains one or more of the applicable disqualifying acts or offenses listed above.

Signature of Affidavit

Date

Note: If you have previously been granted an APD exemption for this disqualifying offense, a copy of the APD exemption letter must be attached

OR

I am a licensed physician, licensed nurse, or other professional and regulated by the Department of Health. I will be holding a position that is within the scope of my licensed practice, and I am not subject to screening provisions of section 393.0655, Florida Statutes

Signature of Affidavit

Date

Position for Provider/Employer listed on pg. 1

Confidentiality Statement

I have been formally instructed regarding facility's policies and procedure for maintaining the confidentiality of all information contained in patient/personnel files and records, as well as any information that is obtained verbally.

I understand that, except as needed to conduct business, patient and /or personnel information may not be discussed with anyone, either inside or outside the facility.

I understand that medical records will to be removed from the facility office unless the patient has signed release of information form and the removal of information is approved by the facility Administrator and/or designee.

I understand that any breach of confidentiality may result in immediate termination of employment.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Vehicle Safety

Any vehicle operated in which consumers are transported shall have a current license plate, carry at least the minimum insurance coverage required by state law, contain a working and tagged fire extinguisher, be operated by a driver holding an appropriate valid driver's license, have working seatbelts and wheelchair tie-downs when applicable, have working heat and air conditioning, and be maintained in a manner to ensure safe transport

The number of transported residents not seated in wheelchairs during the trip shall not exceed the number of available seats in the vehicle.

Residents shall be encouraged to use public transportation in areas where it is available and appropriate to the residents' ability.

Signing this form acknowledges that you understand and will comply.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Mandatory Reporting Requirements:

Form 39.201(1)(a): Any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, as defined in this chapter, or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care shall report such knowledge or suspicion to the department in the manner prescribed in subsection (2)

Caregiver Abuse, Abandonment, and Neglect, Self-Neglect:

The Florida Abuse Hotline accepts reports 24 hours a day and 7 days a week of known or suspected child abuse, neglect, or abandonment

To make a report you can –

Report online at <https://reportabuse.dcf.state.fl.us/>

Call 1-800-962-2873

Florida Relay 711 or TTY 9800-453-5145

Fax your report to 800-914-0000

If you suspect or know of a child or vulnerable adult in immediate danger, call 911.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Applicant Authorization

PLEASE READ BEFORE SIGNING!

If you have any questions regarding the following statements, please ask prior to signing.

Supreme Comfort Care, LLC, does not discriminate in hiring or employment on the basis of race, color, religion, age, disability, veteran status, or status within any group protected by federal, state, or local law. No questions on this application are intended to secure information to be used for any such discriminatory purpose.

This application will be given every consideration, but our receipt of it does not imply that you will be offered employment.

By signing your name below, you authorize investigation of all statements contained herein and the reference and employers listed to give you any and all information concerning your previous employment and any pertinent information they may have, personal or otherwise, and release Supreme Comfort Care, LLC from any liability for any damage that may result from the utilization of such information.

By signing your name below, you certify that all statements made by you on this application are true and complete to the best of your knowledge and that you understand that misrepresentations or omissions may be cause for rejection, or may be cause for subsequent dismissal if you are hired or prosecution.

By signing your name below you, understand that nothing contained in the application or in the interview process is intended to create an employment contract between you (the applicant) and Supreme Comfort Care, LLC. Should this application result in your employment, you have a right to terminate your employment at any time for any reason and Supreme Comfort Care, LLC retains a similar right.

I hereby acknowledge that I have read, understand, and agree to the above statement.

Signature of Applicant _____ Date _____

Personal Supports

Description: Personal supports services provide assistance and training to the recipient in activities of daily living, such as eating, bathing, dressing, personal hygiene, and preparation of meal. When specified in the support plan, this service can also include hereby household chores to make the home sager, such as washing floors, windows and walls; tacking down loose rugs and tiles; moving hereby items or furniture. Services also include non-medical care, ad supervision. This service can provide access to community-based activities that cannot be provided by natural or unpaid community resources without paid support. Personal supports are designed to encourage community integration. Personal supports in supported living are also designed to teach the recipient about home-related responsibilities. This service can also include respite services to a recipient age 21 years or older living in their family home. Respite services provide relief to the caregiver and are incorporated into the personal support service. The provider, to the extent properly qualified and licensed, assists in maintaining a recipient's own home and property as a clean, sanitary and safe environment. This service is provided in support of a goal included in support plan or an identified need to support.

Limitation and Exclusions

Personal Support service providers are not reimbursed separately for transportation and travel costs. These costs are integral components of Personal Support Services and are included in the rate.

Employee Signature _____ Date _____

Provider Signature _____ Date _____

Respite Care

Description: This service is generally used due to a brief planned to emergency absence, or when the primary caregiver is available, but temporarily physically unable to care for or supervise the recipient for a brief period. Who Can Receive Respite care is a service that provides supportive care and supervision to recipients under the age of 21 years when the primary caregiver is unable to perform the duties of a caregiver. Respite care for recipients ate 21 years or older is available as a part of personal supports service family.

Limitation and Exclusions

Respite service providers are not reimbursed separately for transportation and travel costs. The costs are integral components of Respite Services and are included in the rate.

Employee Signature _____ Date _____

Provider Signature _____ Date _____

Life Skills Development Level 1

Companion Description Life Skills Development Level 1 –

Companion services consist of non-medical care, supervision, and socialization activities provided to recipients are 21 years or older. This service must be provided in direct relation to the achievement of the recipient's goals as specified in the recipient's support plan. The service provides access to community-based activities that cannot be provided by natural or other unpaid supports and should be defined as activities most likely to result in increased ability to access community resources without paid support. These services can be scheduled on a regular, long-term basis. Activities can be volunteer activities performed by the recipient as a pre-work activity or activities that connect a recipient to the community. Who Can Receive Recipients must 21 years or older. Who Can Provide Companion services may be provided by licensed home health or hospice agencies. Providers can also be solo or agency providers who are not required to be licensed, certified, or registered. Service Requirements Companion services are limited to the amount, scope, frequency, duration, and intensity of the services described on the recipient's support plan and current approved cost plan.

Limitations and Exclusions

Companion service providers are not reimbursed separately for transportation and travel costs. These costs are integral components of companion services and are included in the rate.

Employee Signature _____ Date _____

Provider Signature _____ Date _____

Statement of Orientation Completion

This is to certify that _____
(Staff Name)

Has successfully completed the agency's program to agency policies and procedures.

Part 1. Completed Service Education in Developmental disabilities and related disorders.

Part 2. Zero tolerance, HIPAA, Direct Core Competency and HIV 101

Part 3. I understand Supreme Comfort Care, LLC. will not be liable for any accidents that I occur and I cannot sue Supreme Comfort Care, LLC. for any reason as I am advised to get my own liability insurance in case of any emergencies or accidents that may occur on the job.

Part 4. I am liable at my own risk to use my personal vehicle to transport clients. I understand that if I am involved in an automobile accident, I am to use my automobile's liability insurance for bodily injury to cover myself and the client. Therefore, it my responsibility to update Supreme Comfort Care, LLC. each and every instance that I renew my Driver's License, Insurance, and Vehicle's Registration.

Part 5. I understand that I am a sub-contractor, which means that I am not eligible for any benefits such as vacation, disability, workers compensation nor unemployment insurance. I understand that I will receive an IRS 1099 Form for the preceding year on February 1st of each year, which is sent to the Internal Revenue Services. I also understand that I will be responsible to pay my own income tax.

Part 6. I acknowledge as a direct care provider, I am to complete a 4 hour in-service hour yearly pertaining to my client's disability,.

Part 7. I acknowledge if there is an incident with the client, it must be reported to my supervisor within 24 hours and an incident report must be completed.

Part 8. I acknowledge that if I notice abuse this is happening to the client I can call 1-800-96-Abuse or report it to my supervisor immediately.

I acknowledge that I have read the above and will abide by them

Staff Signature _____ Date _____

Supervisor Signature _____ Date _____

Employee Checklist

ID	Applicant Name: Applicant Start Date:	Received	Not Received	Exp.	Required
1.1	Direct Care Core Competency				Once
1.2	HIPPA				Annually
1.3	Zero tolerance				3 years
1.4	CPR (Infant, child and adult) and First Aid				2 years
1.5	HIV / Infectious Control				Annually
1.6	2nd Level Background / Clearing house				5 years
1.7	Local Background				5 years
1.8	Affidavit of Good Moral Character				5 years
1.9	4 Reverence Letters				Once
1.10	ID / Social				Once
1.11	High School Diploma / GED				Once
1.12	Resume				Once
1.13	License, Insurance, and Registration				At each renewal
1.14	Agency Application				Yearly If Validation not Done annually
	Other Trainings:				Annually
1.15	Medication Administration				
1.16	Medication Validation				

Employment Document Checklist

Please call ahead to schedule an appointment and remember to specify that you will need an

APD General Background Screening

The cost for the screening is usually around \$90.00 and must be paid by the applicant

APD General-Eligible Level 2 Background Screening Clearance

Date of Clearance: _____

Job Offer Date of Hire: _____

Phase Three: New Employee Orientation & Training

Before a New Hire can begin services a client, the following trainings must be taken with proof of completion
(we will assist):

Zero Tolerance (before hire)

Direct Care Core Competencies (within first 90 days)

Requirements for All Waiver Providers (within first 90 days)

HIPAA (within first 30 days)

HIV/AIDS/Infection Control (within first 90 days)

CPR (Adult/ Child/ Infant) (within first 90 days)

65G-7 Medication Administration Cert and Validation (*only if applicable for the client assigned*)

Best Practices in Support Employment (*for Support Employment Applicants*) (before hire)

Intro. To Social Security Work Incentives (*for Support Living Applicants*) (before hire)

Supported Living Pre-Service Training (*for Supported Living Applicants*) (before hire)

Supreme Comfort Care, LLC New Employee Orientation/Review of Agency Policies & Procedures (within first
30 days)

**Should you require any assistance with meeting any of the above requirements, please do not hesitate to
call the Agency Administrator, Dakeisha Roberson.**

After All Requirements have been met, New Hires are eligible to begin rendering services.

WELCOME ABOARD!!!