EMPLOYMENT APPLICATION

Submit application and attachments to Mountain Home Health Care via:

FAX: (575-758-0560) MAIL: PO BOX 2566, Taos, NM 87571
PERSONAL DELIVERY AT: 630 Paseo del Pueblo Sur #180, Taos, NM

APPLICANT INFORMATION

Position Applying for			Date
Last Name		First	MI
Address			Apartment/Unit #
City		State	ZIP
Home Phone:	Cell Phone:	E-mail Address	
Date Available to Start Work	Desired Salary		

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 so, when?

Highest Licensure/Certification: RN ☐ LPN ☐ CNA ☐ HHA ☐ Caregiver ☐ Companion ☐ Other ☐

CLIENT PLACEMENT PREFERENCE

Where are you interested in working?

Anywhere ☐ North Taos ☐ South Taos ☐ Questa ☐ Peñasco ☐

What types of shifts are you interested in working?

Days ☐ Evenings ☐ Weekends ☐ Respite ☐ Sub Assignments ☐ Overnights ☐

Are you willing to accept an assignment with less than 24 hour notice? Yes ☐ No ☐

Are you willing to care for a client who smokes? Yes ☐ No ☐

Are you willing to care for a client with pets in the home? Yes ☐ No ☐

PLEASE LIST YOUR AVAILABILITY

SUN	MON	TUE	WED	THUR	FRI	SAT
From:	From:	From:	From:	From:	From:	From:
To:	To:	To:	To:	To:	To:	To:

EDUCATION

High School		City/State where located		
From	To	Did you graduate?	YES ☐ NO ☐	Degree
College		City/State where located		
From	To	Did you graduate?	YES ☐ NO ☐	Degree
Other		City/State where located		
From	To	Did you graduate?	YES ☐ NO ☐	Degree

PREVIOUS EMPLOYMENT (REQUIRED)

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.

Signature	Date

REFERENCES (REQUIRED)

Please list three ***professional references.***
Friends and Family members do not count as professional references unless you have been employed by/with them.

Full Name	Relationship
Company	Phone ( )
Address	

Full Name	Relationship
Company	Phone ( )
Address	

Full Name	Relationship
Company	Phone ( )
Address	

EMPLOYMENT CONTINGENCIES:

I understand that if offered a position with Mountain Home Health Care, Inc. , the offer of employment is contingent upon satisfaction of all the following requirements:

As a condition of employment, you will be required to submit to a **Criminal Background Check**. Any offer of employment is conditional and pending clearance.

I must provide evidence of a **current and valid driver's license and current and valid auto insurance** and I must continue to provide proof of these items as long as I remain employed by Mountain Home Health Care, Inc.

Do you have a valid Driver's License? Yes ☐ No ☐

Do you have current, valid Automobile Insurance? Yes ☐ No ☐

As a condition of employment, I understand that I must have a **safe, dependable vehicle**. I understand that my job duties will routinely require me to run errands or transport clients in my personal vehicle. If I do not have a safe, dependable vehicle at any point during my employment, I must notify Mountain Home Health Care, Inc. immediately and I understand that in that circumstance, I will no longer meet the requirements for continued employment and my lack of vehicle will equate to a voluntary resignation by me. I may be temporarily excused from this requirement in the limited circumstance where the client to whom I am assigned signs a disclaimer relieving me of this requirement. This excusal will only be effective during the limited period of my assignment to that client.

Do you have a safe, dependable vehicle? Yes ☐ No ☐

I must **undergo a Tuberculosis (TB) Screen Test** and have it read, prior to working with a client.

DISCLAIMER AND SIGNATURE:

I hereby affirm and acknowledge that I have read, understand and agree to the terms and conditions set forth herein in three (3) pages of this application, and that it is my stated intention to be legally and irremovably bound thereby. I have had the opportunity to raise may questions about any part of this document before signing it, and I attest that my signature below is completely voluntary, without coercion or duress of any kind.

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 including any omissions provided in this application, or subsequent updates to this application or during an interview, regardless of when discovered, may result in the revocation of my offer of employment.

This Employment Application should not be construed as an offer of employment. Any offer of employment by Mountain Home Health Care, Inc. that may follow this Employment Application will be "at-will" and expressly contingent on the requirements described herein.

Full Printed Name: ____ Date: ____________________

Signature: ____

PO BOX 2566
Taos, NM 87571
575-758-4786
Fax: 575-758-0560

AGREEMENT, AUTHORIZATION, WAIVER, AND RELEASE

I hereby authorize The Employer and its agents to investigate my work history, education history, and to conduct personal inquiries. I understand that The Employer will send a copy of this Agreement and Authorization to each individual or entity from whom it is seeking a reference or background information.

I hereby authorize the party receiving a copy of this signed form (including a photocopy or facsimile copy) to provide and release complete information as may be requested, and I hereby waive any claim of confidentiality I might have with regard to such information.

I hereby release any person or entity providing information or records in accordance with this Agreement, Authorization, Waiver, and Release from any and all claims or liability for compliance.

I AM ALSO WAIVING ANY RIGHT OF ACTION, CAUSE OF ACTION, OR OTHER MEANS OF REDRESS I MAY HAVE AGAINST ANY PERSON OR ENTITIY SUPPLYING EMPLOYMENT-RELATED INFORMATION INCLUDING BUT NOT LIMITED TO INFORMATION CONCERNING MY BACKGROUND, WORK HISTORY, AND DISCIPLINARY HISTORY – TO THE EMPLOYER UDNER A GUARANTEE OF CONFIDENTIALITY.

I understand that the information contained in this application and the information submitted by me or obtained pursuant to this agreement and authorization is confidential, for the exclusive use of The Employer and its agents for employment decisions, and will not be transferred to any other entity without my written authorization unless required to be disclosed upon request by either New Mexico or Federal Law.

____ ________________________
Signature of Applicant Date

____
Printed Name of Applicant

APPLICANT SKILLS CHECKLIST

PLEASE CIRCLE "**Y**" IF YOU HAVE THE SKILL
PLEASE CIRCLE "**N**" IF YOU DO NOT WISH TO PERFORM THE TASK
PLEASE CIRCLE "**W**" IF YOU ARE WILLING TO LEARN THE SKILL

TOILETING

Safely Getting Someone On/Off The Toilet	Y	N	W
Changing Adult Briefs/Pads/Depends	Y	N	W
Emptying/Cleaning The Commode	Y	N	W
Emptying/Rinsing Urinal	Y	N	W
Catheter Care	Y	N	W
Ostomy Care	Y	N	W
Cleaning Client After Toileting	Y	N	W
Readjusting Clothing	Y	N	W

HOMEMAKING

Laundry	Y	N	W
Vacuum	Y	N	W
Dust	Y	N	W
Sweep/Mop	Y	N	W
Clean Bathroom/Kitchen/Bedroom	Y	N	W
Wash Dishes	Y	N	W
Change Bed Linen	Y	N	W
Run Errands	Y	N	W

MOBILITY

Assist With Walking	Y	N	W
Lift And Transfer Clients From One Place To Another	Y	N	W
Transfer With Hoyer Lift	Y	N	W
Assist With Repositioning	Y	N	W
Assist With Exercises	Y	N	W

NUTRITION

Prepare Meals	Y	N	W
Encourage Fluids to Prevent Dehydration	Y	N	W
Monitor Special Diet	Y	N	W
Assist With Feeding	Y	N	W
Cut Food	Y	N	W

PERSONAL CARE

Assist With Bed-Bathing	Y	N	W
Foot Soak	Y	N	W
Back Rub Per Request	Y	N	W
Apply Lotion	Y	N	W
Assist With Shave	Y	N	W
Oral Care/Brush Dentures	Y	N	W
Hair Care: Brush/Shampoo/Other	Y	N	W
Nail Care: Clean/File	Y	N	W
Assist With Dressing	Y	N	W

REPORTING

Reporting Concerns To Supervisor	Y	N	W

WORKING WITH CLIENTS WHO HAVE CHALLENGING MENTAL BEHAVIORS, SUCH AS ALZHEIMERS, DEMENTIA, DEVELOPMENTAL DISABILITIES, MENTAL ILLNESS	Y	N	W

SAFETY

Supervise Client For Safety	Y	N	W
Check ERS Button	Y	N	W
Oxygen Precautions	Y	N	W
Cleaning Oxygen Concentrator, Filter And Tubing	Y	N	W
Cleaning Nebulizer	Y	N	W
Cleaning Other Durable Medical Equipment – Wheel Chair, Hospital Bed, Walkers, Bedside Tables	Y	N	W
Training In Universal Precautions	Y	N	W

SUPPORT

Encourage Self Care Skills	Y	N	W
Encourage Socialization	Y	N	W
Medication	Y	N	W
Assist With Self-Administering Of Medications	Y	N	W
Remind To Take Self-Administered Medications	Y	N	W

BACKGROUND CHECK INFORMATION

All Mountain Home Health Care employees working with patients are required to be fingerprinted so that the FBI and the State can conduct a criminal history background check. These fingerprints are required to be submitted to the State within 20 days of the start of employment. Please fill out the following information completely.

Full Name (including your middle name) ____

____

Any other name you have been known by (including maiden name or nickname) __________________

____

____

Complete Mailing Address ____

____

Complete Physical Address____

Have you lived in any state other that New Mexico in the past seven years?

____

____

Citizenship (for example, US) ____

Social Security Number ____

Gender ___________

Ethnicity (White, Native American, Black, etc.) ____________________________________

Height: __________ Weight: __________ Eye color: ____________ Hair color: ____________

Date of Birth: ____________________ Place of Birth: __________________________________

Phone number: ____

Drivers License Number: _________________________ Expiration Date: ___________________

Issuing State: ___________________________