

# A.C.E. Home Health Care Services, Inc.

## Application for Employment

- All information obtained within this application will be held in strict confidence, subject to applicable law.
- Please complete all applicable sections and sign the last page.
- Please print clearly.

A.C.E. HHC prides itself on being an Equal Opportunity Employer. We will not discriminate in employment because of sex, age, race, physical disability, religion, ethnicity, mental disability, marital status, ancestry, or place or origin.

### SECTION 1

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: (    ) \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Are you legally entitled to work in the USA? \_\_\_\_\_

Position (s) applied for: \_\_\_\_\_

Date you are available for employment: \_\_\_\_\_ Wage or salary desired: \_\_\_\_\_

Have you ever worked for A.C.E. before? \_\_\_\_\_ If yes, when? \_\_\_\_\_

### SECTION 2 EDUCATIONAL BACKGROUND

A.C.E. has a company policy stating a minimum educational level of grade 12 or equivalent for all positions.

EDUCATIONAL BACKGROUND – relevant to the position applied for.

Highest level of education completed: \_\_\_\_\_

Name of educational institute: \_\_\_\_\_

What machines or equipment have you operated that relate to the position you have applied for? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are there any skills, experience, or other qualifications that you feel would assist you in performing the duties of the position you have applied for? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION 3 List below your last three employers, starting with the most recent.**

Employer#1 \_\_\_\_\_ Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_  
Reason for Departure from employment: \_\_\_\_\_  
Supervisor's Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Position Held: \_\_\_\_\_  
Duties: \_\_\_\_\_  
\_\_\_\_\_  
May we contact this employer? ( ) Yes ( ) No (If not, state a brief reason): \_\_\_\_\_  
\_\_\_\_\_

Employer#1 \_\_\_\_\_ Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_  
Reason for Departure from employment: \_\_\_\_\_  
Supervisor's Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Position Held: \_\_\_\_\_  
Duties: \_\_\_\_\_  
\_\_\_\_\_  
May we contact this employer? ( ) Yes ( ) No (If not, state a brief reason): \_\_\_\_\_  
\_\_\_\_\_

Employer#1 \_\_\_\_\_ Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_  
Reason for Departure from employment: \_\_\_\_\_  
Supervisor's Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Position Held: \_\_\_\_\_  
Duties: \_\_\_\_\_  
\_\_\_\_\_  
May we contact this employer? ( ) Yes ( ) No (If not, state a brief reason): \_\_\_\_\_  
\_\_\_\_\_

**SECTION 4 Please provide two personal references who are not family members**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Yrs. Known: \_\_\_\_\_  
Phone Number to contact: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Yrs. Known: \_\_\_\_\_  
Phone Number to contact: \_\_\_\_\_ Cell Number: \_\_\_\_\_

**SECTION 5**      **If you are applying for a position that requires driving, please complete this section.**

Do you have a valid drivers license? \_\_\_\_\_ License #: \_\_\_\_\_ State: \_\_\_\_\_

**Note:** If you are selected to attend orientation, you are required to provide a copy of your auto liability insurance coverage sheet and driver’s license. After being hired, a copy of these will be kept in your personnel file and a bi annual update will be required as well as any policy changes in the interim period.

**SECTION 6**      **False information given or implied on an application form is grounds for immediate dismissal without further notice.**

I hereby state that all information provided is accurate and may be verified by you. I agree that I may be discharged if ACE HHC at any time learns of falsification or material omission in the information provided on this application form and related documents. ACE HHC may contact my former employer in connection with the consideration of my employment with them. All references are hereby authorized to release all affiliates, successors, and assigns and all references from any liability that might be claimed because of information provided by such references.

I agree that I will follow all company policies, rules, procedures, and all other directions pertaining to my employment. I understand that ACE HHC reserves the right to add, change, and/or delete any policies, procedures, work rules, and/or benefits at any time.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NO CONSIDERATION OF EMPLOYMENT WILL BE GIVEN TO ANY APPLICANT WHO DOES NOT SIGN THE ABOVE STATEMENT.**

**Note:** Additional personal information will be required to complete benefit forms after being hired.

**Thank you for showing an interest in pursuing a career with A.C.E. Home Health Care Services, Inc.**

***(Applicant to complete this section only)***

I \_\_\_\_\_, hereby give my permission to A.C.E. Home Health Care Services, Inc. to verify my past employment history with your company. Please release all information necessary regarding my past employment.

Maiden Name / Names previously used: \_\_\_\_\_

Applicants Social Security Number: \_\_\_\_\_

Print Name: \_\_\_\_\_

\_\_\_\_\_  
**Applicants Signature**

\_\_\_\_\_  
**Date**

***(This section to be completed by A.C.E. Home Health Care Services Inc. Staffing member)***

To: \_\_\_\_\_

Attention: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

City: \_\_\_\_\_

Fax: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

The above applicant has applied for a position as a \_\_\_\_\_. He / she states they worked for you from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Please complete the following and fax back as soon as possible to (231) 937-7246.**

\_\_\_\_\_  
A.C.E. Home Health Care Services Inc. Signature

\_\_\_\_\_  
Date

***(This section to be completed by former employer)***

1. Was the above applicant employed by your company: \_\_\_\_ yes \_\_\_\_ no
2. Dates applicant was employed with your company: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To \_\_\_\_ / \_\_\_\_ / \_\_\_\_
3. Applicant' position held: \_\_\_\_\_
4. Applicant's Strengths: \_\_\_\_\_
5. Applicant's Weaknesses \_\_\_\_\_
6. Is applicant eligible for rehire: \_\_\_\_ yes \_\_\_\_ no

\_\_\_\_\_  
Completed by: Name / Position

\_\_\_\_\_  
Date

# A.C.E. HOME HEALTH CARE

*"Employee Reference Check"*

***(Applicant to complete this section only)***

I \_\_\_\_\_, hereby give my permission to A.C.E. Home Health Care Services, Inc. to verify my past employment history with your company. Please release all information necessary regarding my past employment.

Maiden Name / Names previously used: \_\_\_\_\_

Applicants Social Security Number: \_\_\_\_\_

Print Name: \_\_\_\_\_

\_\_\_\_\_  
**Applicants Signature**

\_\_\_\_\_  
**Date**

***(This section to be completed by A.C.E. Home Health Care Services Inc. Staffing member)***

To: \_\_\_\_\_

Attention: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

City: \_\_\_\_\_

Fax: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

The above applicant has applied for a position as a \_\_\_\_\_. He / she states they worked for you from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please complete the following and fax back as soon as possible to (231) 937-7246.

\_\_\_\_\_  
A.C.E. Home Health Care Services Inc. Signature

\_\_\_\_\_  
Date

***(This section to be completed by former employer)***

1. Was the above applicant employed by your company: \_\_\_\_ yes \_\_\_\_ no
2. Dates applicant was employed with your company: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To \_\_\_\_ / \_\_\_\_ / \_\_\_\_
3. Applicant's position held: \_\_\_\_\_
4. Applicant's Strengths: \_\_\_\_\_
5. Applicant's Weaknesses: \_\_\_\_\_
6. Is applicant eligible for rehire: \_\_\_\_ yes \_\_\_\_ no

\_\_\_\_\_  
Completed by: Name / Position

\_\_\_\_\_  
Date

# A.C.E. HOME HEALTH CARE

**"Denial of existence of Criminal History as required by Public Act 28 of 2006"**

I have been advised by A.C.E. Home Health Care that it is necessary to conditionally employ, independently contact and/or grant clinical privileges to me prior to receiving all of the results of the state and national criminal history background information required by Public Act 28 of 2006. Accordingly, I make the following representations while this information is obtained and analyzed.

1. I swear under penalty of law that I have not been convicted of a felony or misdemeanor within the applicable time period that makes me ineligible, by law, to work for A.C.E. Home Health Care. I have reviewed the attached list of felonies and misdemeanors prior to making this representation.
2. I am not the subject of an order or disposition under section 16b of Chapter IX of the code of criminal procedure. 1927 PA 175, MCL 769.16(b) relating to finding of not guilty by reason of insanity.
3. I have not been the subject of a substantiated finding of neglect, abuse or misappropriation of property by a state or federal agency pursuant to an investigation arising in a skilled nursing facility and conducted in accordance with 42 USC 1395i-3 or 1396r.
4. I agree that, if the information in the criminal history investigation conducted by A.C.E. Home Health Care does not confirm my statements, my employment, contract or clinical privileges will be terminated unless and until I can prove that the information is incorrect. I further agree that if this results in a period of unemployment, suspension, or leave of absence, it will be without compensation and without fringe benefits.
5. I understand that the conditions set forth in Public Act 28 2006 that result in my termination and agree that these conditions are in fact good cause for termination.
6. I am aware that the provision of false information regarding my identity or criminal history is a crime punishable by fines and/or imprisonment.
7. The Legal Guide is available to me upon my request that list the prohibited offenses as defined in P.A. 27, 28, and 29.

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Print Name

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Signature

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Date

# A.C.E. HOME HEALTH CARE SERVICES, INC.

## "Consent for Criminal History Background Check"

As a prospective employee of A.C.E. Home Health Care Services Inc., I understand that it is this Agency's policy to secure conviction criminal history information as part of their pre-employment screening process using the information found below.

### (PLEASE PRINT)

Complete Name: \_\_\_\_\_  
(First) (Middle) (Last)

Date of Birth	Place of Birth	Height	Weight	Sex
Hair Color	Eye Color	Race	County Lives in	State Born in

Names previously used / Maiden Name: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Have you lived in Michigan for more than 3 years? \_\_\_\_\_ yes \_\_\_\_\_ no

Do you have any felony charges pending against you? \_\_\_\_\_ yes \_\_\_\_\_ no

Have you ever pled guilty or been convicted of a crime? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please provide explanation:

\_\_\_\_\_  
\_\_\_\_\_

Are you currently licensed or certified by the state of Michigan in a health care related occupation?

\_\_\_\_\_ No \_\_\_\_\_ Yes If yes, what type? RN LPN CENA PT OT ST MSW BSW

License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

As a prospective employee, I understand that the above information is required in order for the agency to request that a criminal background check be conducted. I also understand that a criminal background check will only be performed following a good faith offer.

If the agency's representative determines that the actions by a court of law against a prospective employee are such that they indicate the applicant is unsuited to work in the home health care field, the applicant will not be considered for employment.

A report may be made to the Nurse Aide Registry or State Licensing Agency, if deemed appropriate.

I understand the importance of protecting the safety and well being of the home health agency's clients. I understand that conviction of a crime after employment may be deemed cause for dismissal if there is an indication of behavior that might place clients at risk.

A copy of the background check may be obtained within 60 days upon written request of the applicant.

\_\_\_\_\_  
Consent Signature of Applicant

\_\_\_\_\_  
Date

**A.C.E. HOME HEALTH CARE SERVICES, INC.**  
*“Conditional Job Offer”*

This good faith offer is also conditioned upon A.C.E. Home Health Care's ability to successfully establish eligibility for employment, independent contract or clinical privileges on a timely basis. The eligibility determination is made at the sole discretion of A.C.E. Home Health Care and will be based not only on A.C.E. Home Health Care's policy on good moral character and references but also the information obtained through the mandatory background check and fingerprinting requirements imposed by Public Acts 28 of 2006.

This conditional offer is also conditioned upon the applicant's full cooperation with the production of acceptable personal identification, obtainment of signed releases, consent forms, criminal history records, fingerprints and the obtainment of any other information required by policy and law. Failure to comply fully with all of the requirements within (14) business days will result in the automatic withdrawal of this offer.

\_\_\_\_\_  
Applicants Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
A.C.E. Staff Signature

\_\_\_\_\_  
Date