CHESTERFIELD HEALTH SERVICES, INC.
Home Health, Staffing, and Pharmacy

Applicant's Checklist

(Applicant keeps this page for reference)

Required Documents for Employment:

☐ Identification Document

☐ Employment Eligibility Document

Required from Drivers:

☐ Valid Driver License

☐ Valid Auto Insurance Certificate / Declaration Page

☐ Acceptable Driving Record

☐ Vehicle Maintenance Acknowledgement

Required Background Check:

☐ Name and Date of Birth Check

☐ Fingerprint Check

Required Training:

☐ ***Safety & Orientation Training (5hrs paid training)*** - must be completed before hands-on service with clients

☐ ***Basic Training (70hrs paid training)*** - must be completed within 120 days of hire

☐ ***Examination*** – must pass Home Care Aide exam given by Prometric

☐ ***Certification*** – must be certified to work as a Home Care Aide by Department of Health within 200 days of hire

Those Exempt from training are.
(CNA, LPN, RN, and HCA who worked and completed required training in 2011 are EXEMPT)

CHESTERFIELD HEALTH SERVICES, INC.
Home Health, Staffing, and Pharmacy

EMPLOYMENT APPLICATION

For

Home Healthcare/Home Care Assistant

Office Locations: ☐ King County ☐ Everett ☐ Kent ☐ Longview ☐ Vancouver
☐ Spokane ☐ Whitman ☐ Yakima ☐ Tri-Cities ☐ Tri-Counties ☐ Walla Walla
☐ Goldendale ☐ Stevenson ☐ Tacoma

Please print clearly. Do not leave any blank spaces.

Name (last, first)			**Date of Birth**	**Application Date**
Mailing Address		**City**	**State**	**Zip Code**
Home Phone #	**Cell Phone #**	**Other Phone #**	**Email Address**	

I want to receive information from Chesterfield Services via phone text messages. ☐**Yes** ☐**No**

I want to receive information from Chesterfield Services via email. ☐**Yes** ☐**No**

Desired Start Date	**Are you at least 18?**	**How did you hear about Chesterfield?**
	☐ Yes ☐ No	**Have you ever worked for Chesterfield?** ☐ **Yes** ☐ **No**

Emergency Contact Name	**Relationship**	**Home Phone #**	**Cell Phone #**
Emergency Contact Name	**Relationship**	**Home Phone #**	**Cell Phone #**

1. Do you have the legal right to work in the United States for any employers? ☐ Yes ☐ No

2. How many years have you lived in Washington State without living in another state?
_____years/_____months

3. Do you have a valid driver's license? ☐ Yes ☐ No

Driver's License #:_____ Expiration Date:_____

4. Do you have a serviceable motor vehicle? ☐ Yes ☐ No

5. Is the motor vehicle currently insured? ☐ Yes ☐ No

EDUCATION & TRAINING

School/Training	Name & Location	Course of Study	Years Attended	Degree/Certificate
High School				
Vocational				
College				
Other				

Please list any special skills and/or trainings you have had that will help you perform in this line of work:

_____

_____

_____

_____

Why do you want to work for Chesterfield Health Services?

_____

_____

_____

_____

SKILLS ASSESSMENT

If you have questions about the following home care duties, please ask one of our Program Managers for more information.

Are you able and/or willing to perform these home care tasks/duties? Rate your skill by circling a number next to the tasks/duties: (4 = Excellent, 3 = Good, 2 = Poor, 1 = No Experience)

Ambulation	4	3	2	1	Meal Preparation	4	3	2	1
Assistance w/ Travel	4	3	2	1	Medication Reminders	4	3	2	1
Bathing	4	3	2	1	Personal Hygiene	4	3	2	1
Body Care	4	3	2	1	Positioning	4	3	2	1
Dressing	4	3	2	1	Shopping/Errands	4	3	2	1
Eating (assistance w/ eating)	4	3	2	1	Supervision	4	3	2	1
Grooming	4	3	2	1	Toileting	4	3	2	1
Housework	4	3	2	1	Transferring	4	3	2	1
Laundry	4	3	2	1	Telephone Assistance	4	3	2	1
Meal Planning/Diets	4	3	2	1	Companionship	4	3	2	1
Diaper Change	4	3	2	1	Perineal Care	4	3	2	1
Assistance w/ Wheelchair	4	3	2	1	Bending/Kneeling	4	3	2	1

EMPLOYMENT HISTORY

Employer (present or most recent)	Telephone	Address
Position	**Supervisor**	**Reason for Leaving**

Dates of Employment	Starting Salary	Final Salary	May we contact this employer?
From: To:			☐ Yes ☐ No

Describe your duties (It is important to be specific and thorough.)

Employer (Previous)	Telephone	Address
Position	**Supervisor**	**Reason for Leaving**

Dates of Employment	Starting Salary	Final Salary	May we contact this employer?
From: To:			☐ Yes ☐ No

Describe your duties (It is important to be specific and thorough.)

Employer (Previous)	Telephone	Address
Position	**Supervisor**	**Reason for Leaving**

Dates of Employment	Starting Salary	Final Salary	May we contact this employer?
From: To:			☐ Yes ☐ No

Describe your duties (It is important to be specific and thorough.)

CHESTERFIELD SERVICES, INC.

1st Reference

Applicant Name:_____

Three (3) professional references are required. You may provide references from a personal source only if you do not have a professional source. Professional references are people with whom you have worked in the past or have had other professional relationships such as teachers or manager/supervisor. Personal references may be your coworkers or friends. FAMILY MEMBERS CANNOT BE REFERENCES.

Reference Name	Reference Title	Reference Type
		☐ Professional ☐ Personal
Reference Phone #	Reference Fax #	Reference Email
Company Name		Applicant Title
Applicant Employment Dates		Applicant Salary
From: ____/____/____ To: ____/____/____		Starting: $_____ Ending: $_____
By signing below, I authorize Chesterfield staff to check my references.		
Applicant signature:_____		Date:_____

**************THE SECTION BELOW IS FOR REFEREE OR CHESTERFIELD STAFF**************

☐ **Phone** ☐ **Fax** ☐ **Email**

1. Please rate the applicant on a scale from 0 to 5 (with 5 being "excellent" and 0 is "not observed").	*Please circle a number.*					
	Excellent ←					**Not Observed**
Punctuality:	5	4	3	2	1	0
Reliability:	5	4	3	2	1	0
Honesty & Integrity:	5	4	3	2	1	0
Working Relationship with Others:	5	4	3	2	1	0
Ability to Follow Directions:	5	4	3	2	1	0
Work Experience:	5	4	3	2	1	0
Quality of Work:	5	4	3	2	1	0
Ability to manage conflict, stress, pressure, and crisis:	5	4	3	2	1	0

2. How long have you known the applicant and in what capacity?

3. The applicant is being considered for the Home Care Aide (Caregiver) position, which allows he/she unsupervised access to vulnerable adults. Do you think he/she is a good fit? Why or why not?

4. Does the applicant exhibit good judgment? Please provide an example.

5. Is the applicant re-hirable? Why or why not?

6. Please confirm the employment dates. **(look above)**

Comments:_____

Recommendation: ☐ Hire ☐ Do Not Hire

Name (staff or referee) **Signature** **Date**

CHESTERFIELD SERVICES, INC.

2nd Reference

Applicant Name:_____

Three (3) professional references are required. You may provide references from a personal source only if you do not have a professional source. Professional references are people with whom you have worked in the past or have had other professional relationships such as teachers or manager/supervisor. Personal references may be your coworkers or friends. FAMILY MEMBERS CANNOT BE REFERENCES.

Reference Name	Reference Title	Reference Type
		☐ Professional ☐ Personal
Reference Phone #	Reference Fax #	Reference Email
Company Name		Applicant Title
Applicant Employment Dates		Applicant Salary
From: ____/____/____ To: ____/____/____		Starting: $_____ Ending: $_____
By signing below, I authorize Chesterfield staff to check my references.		
Applicant signature:_____		Date:_____

**************THE SECTION BELOW IS FOR REFEREE OR CHESTERFIELD STAFF**************

☐ **Phone** ☐ **Fax** ☐ **Email**

1. Please rate the applicant on a scale from 0 to 5 (with 5 being "excellent" and 0 is "not observed").	*Please circle a number.*					
	Excellent ◄					**Not Observed**
Punctuality:	5	4	3	2	1	0
Reliability:	5	4	3	2	1	0
Honesty & Integrity:	5	4	3	2	1	0
Working Relationship with Others:	5	4	3	2	1	0
Ability to Follow Directions:	5	4	3	2	1	0
Work Experience:	5	4	3	2	1	0
Quality of Work:	5	4	3	2	1	0
Ability to manage conflict, stress, pressure, and crisis:	5	4	3	2	1	0

2. How long have you known the applicant and in what capacity?

3. The applicant is being considered for the Home Care Aide (Caregiver) position, which allows he/she unsupervised access to vulnerable adults. Do you think he/she is a good fit? Why or why not?

4. Does the applicant exhibit good judgment? Please provide an example.

5. Is the applicant re-hirable? Why or why not?

6. Please confirm the employment dates. **(look above)**

Comments:_____

Recommendation: ☐ Hire ☐ Do Not Hire

_____

Name (staff or referee) **Signature** **Date**

Worker Availability

(Please complete each section)

Answering "Yes" to any of these questions will not prevent you from being considered for employment.

1. Do you want **full-time** or **part-time** assignments?_____
2. Would you be available for on-call or substitute work?.....☐Y ☐N
3. Do you smoke?.....☐Y ☐N
4. Will you work for a smoker?.....☐Y ☐N
5. Do you prefer to work for a male or female client?_____
6. Do you have any allergies?.....☐Y ☐N
   If "Yes", please explain:
   _____
7. Will you work with clients who have pets?.....☐Y ☐N
   If "Yes", please explain:
   _____
8. Do you have any physical limitations?.....☐Y ☐N
   If "Yes," please explain:_____
9. Do you have the ability to lift objects of up to 35 pounds?..(*You will be required to demonstrate through physical lifting.*).....☐Y ☐N
10. Equipment used? ☐ Hoyer Lift ☐ Gait Belt ☐ Slideboard ☐ Scooter ☐ Other_____
11. Do you have…? ☐ HCA ☐ CNA ☐ NAR ☐ ND ☐ CPR ☐ FCG ☐ CE
12. What language(s) do you speak? (List in order of proficiency)
    _____
13. English level?.....☐ Low ☐ Medium ☐ High
14. Will you learn new ways to cook if requested?.....☐Y ☐N
15. Please write the hours that you are likely to be available for work each day of the week.

Day	Morning 6:00am to 12:00pm	Afternoon 12:01pm-6:00pm	Night 6:01pm to 6:00am
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

ADDITIONAL INFORMATION

I certify that the information provided by me in this application is complete, truthful, an accurate to the best of my knowledge. I understand and agree that my failure to provide complete, truthful and accurate information on this application may result in denial of employment, or, if already employed, immediate termination. I understand that my continuous employment may be contingent upon passing for illegal drugs, a health review physical, proof of employment eligibility and/or reference and criminal background check. I authorize Chesterfield health Services Inc. and its personnel to contact any and all references I have listed on this application for relevant information and release all such persons from all claims, liabilities and damages for whatever reason arising out of furnishing said information. If I am employed, I agree to conform to the rules and regulations of Chesterfield Health Services Inc. I understand that Chesterfield Health Services Inc. is an Equal Opportunity Employer and that all applicants will receive consideration for employment without regard to race, religion, political affiliation, color, gender, age, national origin, disability, marital status, or veteran status.

Name (print) **Signature** **Date**

FOR OFFICE USE ONLY

Skill Level:	☐ Low	☐ Medium	☐ High	Orientation Date:	_____
Skills Proficiency:	☐ Low	☒ Medium	☐ High	References Checked on:	_____
CNA/NAR/LPN:	☐ Yes	☒ No		Date of Hire:	_____
DL/Insurance:	☒ Yes	☐ No		Starting Salary:	_____

Washington State Department of Social & Health Services
Transforming lives

Background Check Authorization

PROCESSING CODE
Fingerprint Required

SECTION 1. ENTITY INFORMATION (COMPLETED BY DSHS STAFF, PROVIDER, APPLICANT, LICENSEE, AND/OR CONTRACTOR)

1A. ENTITY REQUESTING THE BACKGROUND CHECK	1B. ENTIRE ADDRESS OF ENTITY LISTED IN BOX 1A	1C. NAME OF SECONDARY ENTITY
Chesterfield Services, Inc.	**703 Columbia St. Seattle, WA 98104**	

2. REQUIRED: NAME AND SIGNATURE OF PERSON REQUESTING THE BACKGROUND CHECK

PRINTED NAME: **Yeshewalul, Kumneger** SIGNATURE:

3. REQUIRED ONLY FOR DSHS STATE EMPLOYMENT

DSHS POSITION NUMBER _____ (WRITE NONE IF NONE) DSHS JOB CLASSIFICATION: _____ PERSONNEL IDENTIFICATION NUMBER: _____

☐ Permanent appointment ☐ Non-permanent appointment ☐ Work study / student internship ☐ Volunteer ☐ Acting

4. REQUIRED: BCCU ACCOUNT NUMBER	5. DSHS ID NUMBER OR NAME
80000211	**HCS - Seattle**

SECTION 2. THIS SECTION IS FOR APPLICANT INFORMATION ONLY (THE PERSON TO BE CHECKED IS THE APPLICANT)

6. SOCIAL SECURITY NUMBER	7. REQUIRED: DATE OF BIRTH (MM/DD/YYYY)	8. PRINT YOUR E-MAIL ADDRESS

9. REQUIRED: PRINT YOUR NAME AS IT IS LISTED ON YOUR DRIVER'S LICENSE OR OTHER PHOTO ID. WRITE N/A IN THE BOX IF YOU DON'T HAVE A NAME TO ENTER.

FIRST:	MIDDLE:	LAST:

10. REQUIRED: PRINT ALL OTHER FIRST, MIDDLE AND LAST NAMES YOU HAVE USED. WRITE N/A IN THE BOX IF YOU DON'T HAVE A NAME TO ENTER.

FIRST:	MIDDLE:	LAST:

REQUIRED: SELF DISCLOSURE QUESTIONS. SEE INSTRUCTIONS.

You must answer Questions 11A through 14. Attach an additional sheet of paper if you need to list additional crimes or pending charges.

11A. Have you been convicted of any crime? If yes, fill in the blanks below. ☐ Yes ☐ No

_____ Degree: _____ State: __ Conviction date: __/__/____

11B. Do you have charges (pending) against you for any crime? If yes, fill in the blanks below. ☐ Yes ☐ No

_____ Degree: _____ State: __

12. Has a court or state agency ever issued you an order or other final notification stating that you have sexually abused, physically abused, neglected, abandoned, or exploited a child, juvenile, or vulnerable adult? ☐ Yes ☐ No

13. Has a government agency ever denied, terminated, or revoked your contract or license for failing to care for children, juveniles, or vulnerable adults; or have you ever given up your contract or license because a government agency was taking action against you for failing to care for children, juveniles, or vulnerable adults? ☐ Yes ☐ No

14. Has a court ever entered any of the following against you for abuse, sexual abuse, neglect, abandonment, domestic violence, exploitation, or financial exploitation of a vulnerable adult, juvenile or child? ☐ Yes ☐ No

- Permanent* vulnerable adult protection order / restraining order, either active or expired, under RCW 74.34.
- Sexual assault protection order under RCW 7.90.
- Permanent* civil anti-harassment protection order, either active or expired, under RCW 10.14.

See Instructions for description of "permanent."

15. REQUIRED: PRINT YOUR DRIVER'S LICENSE OR STATE IDENTIFICATION NUMBER (WRITE NONE IF NONE)	REQUIRED: PRINT THE NAME OF THE STATE ON YOUR LICENSE OR ID

16. REQUIRED

Have you lived in any state or country other than Washington State within the last three years (36 months)? ☐ Yes ☐ No

17. A. REQUIRED: PRINT YOUR MAILING ADDRESS WHERE WE CAN SEND YOU CONFIDENTIAL INFORMATION

APT. NO. CITY STATE ZIP CODE

B. REQUIRED: PRINT THE STREET ADDRESS WHERE YOU LIVE NOW (WRITE "SAME" IF YOUR STREET ADDRESS IS THE SAME AS YOUR MAILING ADDRESS)

APT. NO. CITY STATE ZIP CODE

C. REQUIRED: GIVE THE DAYTIME AREA CODE AND TELEPHONE NUMBER WHERE YOU CAN BE REACHED

18. I am the person named above. If I do not tell the whole truth on this form, I understand I can be charged with perjury and I may not be allowed to work with vulnerable adults, juveniles or children. I understand and agree my signature in box number 19 means:

- I give DSHS permission to check my background with any governmental entity and law enforcement agency.
- My background check result may include prior self-disclosure information and fingerprint results that are contained in the DSHS Background Check System and that this information will be reported as allowed by federal or state law.
- If a final finding is identified, DSHS will report only my name and that a final finding was identified on the background check result.
- DSHS will give my background check result to the persons or entities named in Section 1 and may release my background check results to other persons or entities when the law authorizes or requires DSHS to do so. Fingerprint rap sheets are provided if allowed by federal or state law.
- The entity requesting this background check must submit this form to the Background Check Central Unit within the timeframe required by the DSHS oversight program.

19. REQUIRED: YOUR SIGNATURE. YOUR PARENT OR GUARDIAN'S SIGNATURE IF YOU ARE UNDER 18.	20. REQUIRED: TODAY'S DATE (MM/DD/YYYY)

PROGRAM USE – FOLLOW INSTRUCTIONS PROVIDED BY YOUR DSHS OVERSIGHT PROGRAM

Washington State Department of Social & Health Services

Fingerprint-Based Background Check Notice

Information about your fingerprint-based background check:

1. In order to determine a person's character, competence and suitability to have unsupervised access to vulnerable individuals, the Department of Social and Health Services requires a background check that is based upon the person's fingerprints. These background checks are required by several state laws, including RCW 43.43.837.
2. Your fingerprints will be used to check the criminal history record files that are kept by the Washington State Patrol (WSP) and the Federal Bureau of Investigation (FBI). Once the fingerprint check is complete, you may obtain a copy of your background check result by contacting the Background Check Central Unit at 360-902-0299 or BCCUInquiry@dshs.wa.gov.
3. If you believe the results of your background check are not complete or are wrong, you have an opportunity to complete or challenge the accuracy of the information as described below.
   a. The background check result letter explains how to correct information that was provided by the Washington State Patrol, the Washington Courts, the Department of Corrections, or the Department of Health.
   b. There are two ways to correct information on the FBI Identification Record:
      - Contact the state or federal agency or agencies that provided the information to the FBI; or
      - Send a written challenge request to the FBI's Criminal Justice Information Services (CJIS) Division by writing to the following address:

        FBI CJIS Division
        Attention: Correspondence Group
        1000 Custer Hollow Road
        Clarksburg, WV 26306

   Your written request to the FBI should clearly identify the information that you feel is inaccurate or incomplete and should include copies of any available proof or documents that support your claim. For example, if information about what happened to a criminal charge against you is incorrect or missing, you may submit documentation from the court or the office that prosecuted the offense. The Correspondence Group will contact appropriate agencies to try to verify or correct challenged entries for you. When the FBI receives official communication from the agency with jurisdiction over the matter, the FBI will make appropriate changes and notify you of the outcome. (This process is described in 28 C.F.R. § 16.34.)
4. The Federal Bureau of Investigation Privacy Act Statement is available on the Background Check Central Unit website at http://www.dshs.wa.gov/bccu/index.shtml.

By signing this notification I acknowledge that:

I received a copy of this notice because I am required to have a fingerprint-based background check. The person or entity that requested the background check is required to keep a copy of this signed notice for their records and to return the original notice to me. I will be notified of the result of my background check when the person or entity that requested the background check received the final fingerprint result letter.

APPLICANT SIGNATURE	DATE	PRINTED NAME

CHESTERFIELD SERVICES INC.

DISCLOSURE STATEMENT

Employee Name:_____

1. **Have you ever been convicted of any crime against children or other persons?** ☐**Yes** ☐**No**
   DEFINITION: Aggravated murder, first or second degree murder, first or second degree kidnapping; first, second or third degree assault, first or second or third degree assault of a child, first, second or third degree rape; first, second or third degree rape of a child; first or second degree robbery; first degree arson; first degree burglary; first for second degree manslaughter, first or second degree extortion; indecent liberties; incest, vehicular homicide; first degree promotion of prostitution; communication with a minor, first or second degree criminal mistreatment, child abuse or neglect as defined in RCW 26.44.020; first degree custodial interference; malicious harassment, first, second or third degree molestation; first or second degree sexual misconduct with a minor; patronizing a juvenile prostitute; child abandonment; promoting pornography; selling or distributing erotic materials to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution, felony indecent exposure; criminal abandonment, or any of these crimes as they may be renamed in the future.

2. **Have you ever been convicted of crimes relating to financial exploitation if the victim was a vulnerable adult?** ☐**Yes** ☐**No**
   DEFINITION: A conviction for first, second, or third degree extortion; first, second, or third degree theft; first or second degree robbery; forgery; or any of these crimes that may be renamed in the future. A vulnerable adult is an adult who lacks the functional, mental or physical ability to care for themselves.

3. **Have you ever been convicted of crimes related to drugs?** ☐**Yes** ☐**No**
   DEFINITION: A conviction of a crime to manufacture, deliver, or possession with the intent to manufacture or deliver a controlled substance.

4. **Have you ever been found in any dependency action under RCW 13.34 to have sexually assaulted or exploited any minor or to have physically abused any minor?** ☐**Yes** ☐**No**

5. **Have you ever been found by the court in a domestic relations proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor?** ☐**Yes** ☐**No**

6. **Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult?** ☐**Yes** ☐**No**
   DEFINITION: Any final decision issued by a disciplining authority under chapter 18.130 RCW or the secretary of the Department of Health for the following businesses or professions: chiropractic, dentistry, dental hygiene, massage, midwifery, naturopathy, osteopathic medicine and surgery, physical therapy, physicians, practical nursing, registered nursing, and psychology.

7. **Have you ever been found by a court in a protection proceeding under chapter 74.34 RCW to have abused or financially exploited a vulnerable adult?** ☐**Yes** ☐**No**
   DEFINITION: The illegal or improper use of a vulnerable adult or that adult's resources for another person's profit or advantage.

8. **Have you ever been convicted of any other criminal offense?** ☐**Yes** ☐**No**
   If yes, state:_____

_____ _____
Employee Signature Date