Employment Application

Applicant Information

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

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

Social Security Number: _____ Date Of Birth: _____ Date Available: _____

Position Applied For: ☐ Home & Community Based Services (HCBS)

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 yes, when? _____

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain: _____

Emergency Contact Information

Full Name: _____ Relation: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

Phone: _____ Email: _____

Prior Experience

Have you had any previous experience in your life taking care of children or vulnerable adults? 6 months of experience is required.

☐ Yes ☐ No From: _____ To: _____

If Yes, explain : _____

Education

High School: _____ Address: _____

From: _____ To: _____ YES ☐ NO ☐ Diploma: _____

College: _____ Address: _____

From: _____ To: _____ YES ☐ NO ☐ Degree: _____

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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.

Signature: _____ Date: _____

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Transportation Waiver

If I transport, I understand and agree to adhere to the standards set forth by AZHBS to be qualified to transport consumers. Those standards are but not limited to:

- Proof of valid and current AZ driver's license
- Proof of valid and current AZ vehicle registration
- Proof of valid and current AZ state minimum required vehicle insurance
- Current MVD record
- Vehicle meets agency requirements

I understand AZHBS will not be held accountable or responsible civilly, criminally, or financially for any damages incurred as a result of myself or another DCW employed by AZHBS transporting a consumer in the course of their work day as agreed by the consumer/consumer representative and/or other interested parties.

Print Name:	Signature:	Date:

Waiving the option to transport (**I do not** want to transport)

I waive the option to transport consumers that I serve at AZHBS at this time. I understand that if I choose to transport in the future I must update this transportation form and meet the requirements stated above to qualify.

Print Name:	Signature:	Date:

HIPAA

BY SIGNING THIS FORM, YOU, THE EMPLOYEE, UNDERSTANDS YOU MUST KEEP ALL CONSUMER INFORMATION PRIVATE ACCORDING TO HIPPA COMPLIANCE. THE HIPPA PRIVACY RULE PROVIDES FEDERAL PROTECTONS FOR PERNONAL HEALTH INFORMATION HELD BY COVERED ENTITIES AND GIVES PATIENTS AN ARRAY OF RIGHTS WITH RESPECT TO THAT INFORMATION. AT THE SAME TIME, THE PRIVACY RULE IS BALANCED SO THAT IT PERMITS THE DISCLOSURE OF PERSONAL HEALTH INFORMATION NEEDED FOR PATIENT CARE AND OTHER IMPORTANT PURPOSES.

THE SECURITY RULE SPECIFIES A SERIES OF ADMINISTRATIVE, PHYSICAL, AND TECHNICAL SAFEGUARDS FOR COVERED ENTITIES TO USE TO ASSURE THE CONFIDENTIALITY, INTEGRITY, AND AVAILABILITY OF ELECTRONIC PROTECTED HEALTH INFORMAITON.

Print Employee Name:	Signature:	Date: