EMPLOYMENT APPLICATION
(Equal Opportunity Employer)

READ CAREFULLY BEFORE COMPLETING APPLICATION
Please complete the entire application. An incomplete application will not be considered. All information submitted is subjected to verification. Any false or misleading statement may result in disqualification or termination.

Please print clearly in ink

Name: _____ S.S #: ____-____-____ D.O.B: ____/____/____
Last First Middle

Address: _____
Street City State Zip Code

Phone: (____) _____-_____ Alternate Phone: (_____) _____-_____

Position Applying for: _____

Travel Side (area preferred to work): _____

Date Available: ____/_____/_____ □ Full time □Part time Salary Requested: _____. _____

In Case of Emergency Notify, Name: _____ Relationship: _____

Address: _____ Phone: (____) _____-_____

List any acquaintances and/ or relatives employed by **ASSURANCEJ HOMECARE SERVICES, INC.**

_____

Who referred you to **ASSURANCEJ HOMECARE SERVICES, INC.**?

_____

Email Address: _____

****

Please answer the following questions

1. Have you previously been employed by **ASSURANCEJ HOMECARE SERVICES, INC.**? __ Yes __ No
2. Have you ever served in the Military? __ Yes __ No

If Yes, what Branch? _____ Discharge Date: ____/_____/_____

3. Are you currently in the Reserve? __ Yes __ No

If Yes, what Branch? _____

4. Have you ever been convicted of a Felony? __ Yes __ No

If Yes, what were you charged with:

_____

_____

****

EDUCATION

	Name and Location of School	Years Attended	Did you Graduate?	Subjects Studied
High School				
College/University				
Technical/Business School				

****

Professional License/Certification

Type: □ RN □ LVN □ CNA □OTHER:

License/Certification #: _____ State: _____ Exp. Date: _____/_____/_____

****

Technical Skills

Check all that apply to you:

□ Typing _____ wpm

□ Computer Programs:

_____

Foreign Language Spoken: _____ Written: _____

****

Employment History

List the most recent position first. (Please provide at least 5 years if available)

1. Employment dates from: ____/____/_____ to ____/____/_____

Company: _____ Salary: _____

Address: _____ Supervisor: _____

Phone: (____) _____-_____ Job Title: _____

Job Duties: _____

Reason for Leaving: _____

2. Employment dates from: ____/____/_____ to ____/____/_____

Company: _____ Salary: _____

Address: _____ Supervisor: _____

Phone: (____)_____-_____ Job Title: _____

Job Duties: _____

Reason for Leaving: _____

3. Employment dates from: ____/____/_____ to ____/____/_____

Company: _____ Salary: _____

Address: _____ Supervisor: _____

Phone: (____) _____-_____ Job Title: _____

Job Duties: _____

Reason for Leaving: _____

4. Employment dates from: ____/____/_____ to ____/____/_____

Company: _____ Salary: _____

Address: _____ Supervisor: _____

Phone: (____)_____-_____ Job Title: _____

Job Duties: _____

Reason for Leaving: _____

****

References

List three references (not related), who have known you for at least one year.

Reference Name	Address	Phone Number	Years Known	How Do You Know Them?
		( ) -		
		( ) -		
		( ) -		

ASSURANCEJ HOMECARE SERVICES, INC. Is an equal opportunity employer, and selects the best matched individual for the job based upon related qualifications, regardless of race, color, creed, sex, national origin, age, handicap or other protected group under state, federal or local Equal Opportunity Laws.

I UNDERSTAND AND AGREE THAT:

Any material misrepresented of deliberate omission of fact in my application may be justification for refusal of, or if employed termination from employment.

It is my understanding that ASSURANCEJ HOMECARE SERVICES, INC. will make a thorough investigation of my entire work history and may verify all data given in my application for employment, related papers, or oral interview. I authorize such investigation and the released from liability any person giving or receiving of any information requested by ASSURANCEJ HOMECARE SERVICES, INC. and released from liability any person giving or receiving such information. I understand that falsification of data so given or other derogatory information discovered as a result of this investigation may prevent my being hired may subject me to immediate dismissal.

I agree that my employment may be terminated by ASSURANCEJ HOMECARE SERVICES, INC. at any time without liability for wages and salary except such as may have been earned at the date of such termination. If requested by the management at any time, I agree to submit to search of my person or locker that may be assigned to me, and hereby waive all claims of damages on account such examination. I authorize any physician or hospital to release any information which may be necessary to determine my ability to perform the duties of a job I am being considered for prior to employment or in the future during examination by a qualified physician at the discretion of my employer. I understand that the result of my medical exam is the property of ASSURANCEJ HOMECARE SERVICES, INC. and will be kept confidential to the full extent of the law.

Although management makes every effort to accommodate individual preferences, business needs may at time the following conditions mandatory: overtime, shift work, a rotating work schedule other than Monday through Friday. I understand and accept these as conditions of my continuing employment.

I understand that I am employed, such employment is for no definite period of time and that association can change wages, benefits, and conditions at any time. I agree that if for any reason I missed being paid during a pay period; I will be paid next pay period.

I, the undersigned, certify that I have read and fully comprehend this form in its entirety and that the information provided is true and complete to the best of my knowledge. I understand that should any statement I made prove false, misleading or erroneous, it may result in the rejection of my application. I authorize the Agency to obtain from my present (unless otherwise indicated) and past employers all data needed to support this application. I further understand that this application becomes the property of ASSURANCEJ HOMECARE SERVICES, INC. and will not be returned.

Signature: X_____ Date: _____/_____/_____

PAS ATTENDANT

NAME: _____ DATE OF HIRE: ____/____/_____

The PAS Attendant is responsible for providing personal assistance services to the client in accordance with the established service plan to enable the client to function in the home and community.

QUALIFICATIONS

The Agency shall employ an attendant who:

1. Should be at least 18 years of age
2. Can be spouse to client. However, if living with client cannot have job outside the home
3. Can be neither legal nor foster parents of minor children who receive the services
4. Must be free of communicable disease and open infections or wounds
5. Must have reliable transportation
6. Must be able to read and write English.

Duties and responsibilities:

1. Shall perform services as identified on the Service Plan
2. Shall report to the supervisor on the day of awareness of any significant changes in client's condition.
3. Shall report emergency situations to appropriate individuals in accordance with the policies immediately upon awareness.

Physical/Mental/Essential Function of the Job:

1. Must be able to stand and walk throughout majority of shift on various surfaces in client's homes.
2. Must be able to lift and carry items up to 30 pounds, such as mop buckets, groceries, and trash bags.
3. Must be able to push/pull up to various weights while performing tasks, such as pushing client wheelchair and transferring the client.
4. Must be able to climb stairs at various clients' houses.

5. Must be able to bend, turn, and reach objects when performing various job functions such as cleaning throughout the shift.
6. Must be able to handle objects such as wheelchairs, brooms, mops, dishes, and vacuum cleaner.
7. Must be able to communicate effectively with client.
8. Overall environment must be able to work in various degrees of temperature, depending upon client's house setting. Position requires working with various cleaning solvents, fumes, dust, and odors.
9. Must be sensitive to the needs of the aged and disabled, and be conscientious about services client needs.
10. Must not be short tempered, rather must be slow to anger and be able to respond in a calm way as well as be able to work in an often-stressful situation when dealing with patients who may be abusive.
11. Must be alert and able to identify hazards should one occur, and in order to avoid them by reporting immediately, and if directed, should be able to take corrective actions.

I have read the above job descriptions and agree to adhere to them, and all questions have been answered on this date regarding my understanding of the above job descriptions.

Date: ____/____/_____ Employee: _____

Date: ____/____/_____ Supervisor: _____

REPORTS TO: _____

The above listed job descriptions have been reviewed and discussed with me and I have had an opportunity to ask questions regarding same.

_____ _____ ___/___/___

EMPLOYEE/CONTRACTOR SUPERVISOR SIGNATURE DATE

PAS ORIENTATION CHECKLIST NEW HIRES

Employee Name: _____

Topic of Orientation	Initials of Preceptor	Initials of Employee	Date of orientation
1. Job responsibilities			
2. Philosophy and values of community integration and consumer driven care			
3. Report of abuse neglect, and change in client health condition requiring emergency procedures or health services			
4. Personnel Policies			
5. Agency Philosophy and objectives			
6. Universal Precautions/HIV prevention and Hep. B			
7. Safety in the home			
8. Hours of business			
9. Payroll			
10. Patient's Rights			

Supervisor Signature: _____ Date: ___/____/____

Employee Signature: _____ Date: ___/____/____

Providers Orientation Checklist

NAME: _____

	Task	Completed	Reviewed	Initials
	Bathing			
	Dressing			
	Exercise			
	Feeding, Eating			
	Shaving, Oral Care			
	Routine Hair & Skin Care			
	Toileting			
	Transfer			
	Walking			
	Cleaning			
	Laundry			
	Meal Preparation			
	Escort			
	Shopping			
	Assist with Medications			

Employee Signature: X_____ **Date:** _____/_____/_____

Administrative Signature: _____ **Date:** _____/_____/_____

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	___ - ___ - ____		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ ▶ _____

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
AssuranceJ Homecare Services, Inc. **9894 Bissonnet St. #110 Houston, Texas 77036**		**800528462**

PAST EMPLOYMENT REFERENCES

_____ Applicant Name

_____ Company Previously Employed

_____-_____-_____ Social Security Number

_____ Company Address

_____ Supervisor

_____ City, State, Zip Code

_____/_____/_____ Date Employed

(_____)_____-_____ Company Telephone Number

AUTHORIZATION:
I consent to release of all information requested by **ASSURANCEJ HOMECARE SERVICES**, INC. regarding my past employment.

Application Signature: _____ Date: _____/_____/_____

Dear Past Employer:
This applicant listed above has applied for employment with us and has given your name as a reference. Please furnish us with the following information as soon as possible.

	Above Average	Average	Poor
Dependability	_____	_____	_____
Attendance	_____	_____	_____
Knowledge	_____	_____	_____
Cooperation	_____	_____	_____
Initiative	_____	_____	_____
Performance	_____	_____	_____
Overall Rating	_____	_____	_____

Duties Performed_____

_____

Reason for leaving_____

_____

Would you rehire _____

Remarks _____

_____

Signature: _____

Position: _____

Date: ____/____/_____

PAST EMPLOYMENT REFERENCES

_____ Applicant Name

_____ Company Previously Employed

_____-_____-_____ Social Security Number

_____ Company Address

_____ Supervisor

_____ City, State, Zip Code

_____/_____/_____ Date Employed

(_____)_____-_____ Company Telephone Number

AUTHORIZATION:
I consent to release of all information requested by **ASSURANCEJ HOMECARE SERVICES,** INC. regarding my past employment.

Application Signature: _____ Date: ____/_____/_____

Dear Past Employer:
This applicant listed above has applied for employment with us and has given your name as a reference. Please furnish us with the following information as soon as possible.

	Above Average	Average	Poor
Dependability	_____	_____	_____
Attendance	_____	_____	_____
Knowledge	_____	_____	_____
Cooperation	_____	_____	_____
Initiative	_____	_____	_____
Performance	_____	_____	_____
Overall Rating	_____	_____	_____

Duties Performed_____
_____
Reason for leaving_____
_____
Would you rehire _____
Remarks _____
_____

Signature: _____

Position: _____

Date: _____/_____/_____

GENERAL ORIENTATION CHECKLIST

_____ _____
Employee Name Position

_____/_____/_____
Orientation Date

Please Place a check to the left of the area covered.

_____ Philosophy
_____ Organizational Structure
_____ Benefits
_____ Employment Requirements
_____ Dress Code
_____ Communicable Disease
_____ Infection Control
_____ Assignment
_____ Personal Protection Equipment
_____ Availability
_____ Voluntary Termination
_____ Disciplinary Guidelines
_____ Time Slip Procedures
_____ Charting
_____ Health Care Safety
_____ Job Description _____
_____
_____
_____

I have received a copy of the Employee Handbook or policies listed and have read and /or had explained to me, all of the proceeding policies, procedures, rules, requirements, and conditions of employment. I understand them and agree to abide by these and any other applicable Agency policies. I further understand that my failure to abide by them may be cause for termination of employment.

Employee Signature: _____ Date: ____/_____/_____

Oriented By: _____ Date: ____/_____/_____

Name: _____

Address: _____ Phone: (___) _____-_____

Position Applied for: _____ D.O.B: _____/_____/_____

Have you ever had or do you have any of the following?

Condition	Yes	NO	Condition	Yes	No	Condition	Yes	No
Allergies			Fainting Spell			Rupture or Hernia		
Anemia			Gall Bladder Trouble			Sciatica		
Asthma			Hay Fever			Severe Headaches		
Back Pain			Head Injury			Shortness of Breath		
Back Injury			Heart Trouble			Skin Condition or Chronic Rash		
Broken Bones			Hepatitis B			Stomach or Duodenal Ulcer		
Cancer			High Blood Pressure			Tuberculosis		
Complications from Childhood Disease			HIV			Tumor		
diabetes			Kidney Trouble			Varicose Veins		
Dislocation of Joints			Knee Injury			Yellow Jaundice		
Ear Trouble			Mental and /or Nervous Disorders					
Eye Trouble			Rheumatic Fever					

Please write **Yes** or **No** for the following questions:

A. Have you ever had an injury that caused you to lose time from work? _____
B. Have you ever filed a Workers Compensation Claim? _____
C. Do you now or have you ever received any compensation for disability from any source? _____
D. Are you at present under the doctor's care for any condition? _____
E. Are you taking any prescribed medication at this time? _____

Explain any "yes" Answer or list any other illness or prior injury that might affect your ability to perform the essential functions of the position offered: _____

_____

_____

_____

_____

What if any, accommodations do you feel would be needed in order for you to perform the essential functions of the position offered? _____

To the best of my knowledge the foregoing statements are correct and may be used to whatever extent in connection with my application for employment. I know of no condition or disability either current or in the past, which would impair my physical capability in performance of my duties I understand that falsification or fail to disclose this information is grounds for dismissal.

Signature: _____ Date: _____/_____/_____

HEPATITIS B VACCINATION OR DECLINE FORM

I have read and understand the Agency's Policy and Procedure regarding the Hepatitis B Vaccination Program. I understand that due to my occupational exposure to blood or other potentially infectious material; I may be at risk of acquiring the Hepatitis B virus (HBV) infection.

☐ I have received the Hepatitis B vaccine series in the last 12 months

Last date received: _____/_____/_____

☐ I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potential infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Name: _____

Signature: _____ Date: _____/_____/_____

Witness: _____

EMPLOYEE STATEMENT REGARDING THE EMERGENCY PREPAREDNESS POLICY AND PROCEDURES

I, _____ have been provided with copy of the agency policy on emergency preparedness, planning, and implementation that includes any pandemic such as COVID-19, and I understand my role in implementing that policy.

Signature of employee: _____Date:_____

Signature of Agency Supervisor: _____ Date: _____

STATEMENT OF COMPLIANCE

I, _____ an employee of ASSURANCEJ
(Print Name)
HOMECARE SERVICES, INC., do hereby agree to comply with the agency's policy and procedures.

_____ ____/____/____
Employee Signature Date

_____
Title

STATEMENT OF EMPLOYABILITY
CONSENT FOR EMPLOYMENT AND CRIMINAL HISTORY CHECKS

YOU CANNOT WORK IN A POSITION WHICH INVOLVES DIRECT CLIENT CONTACT IF YOU ARE LISTED IN THE EMPLOYEE MISCONDUCT REGISTRY, BARRED IN THE NURSE AIDE REGISTRY, LISTED AS AN EXCLUDED PERSON BY THE OIG OR HAVE BEEN CONVICTED OF ANY OF THE FOLLOWING:

- Chapter 19, Penal Code (criminal homicide);
- Chapter 20, Penal Code (kidnapping and unlawful restraint);
- Section 21.02, Penal Code (continuous sexual abuse of young chills or children),
- Section 21.11, Penal Code (indecency with a child);
- Section 22.011, Penal Code (sexual assault);
- Section 22.02, Penal Code (abandoning or endangering child);
- Section 22.04, Penal Code (injury to a child, elderly individual, or disabled individual);
- Section 22.041, Penal Code (abandoning or endangering child);
- Section 22.08 Penal Code (aiding suicide);
- Section 25.031 Penal Code (agreement to abduct from custody);
- Section 25.08 Penal Code (sale or purchase of a child);
- Section 28.02 Penal Code (arson);
- Section 29.02, Penal Code (robbery);
- Section 29.03 Penal Code (aggravated robbery);
- Section 21.08, Penal Code (indecent exposure);
- Section 21.12, Penal Code (improper relationship between educator and student);
- Section 21.15, Penal Code (improper photography or visual recording);
- Section 22.05, Penal Code (deadly conduct);
- Section 22.021, Penal Code (aggravated sexual assault);
- Section 22.07, Penal Code (terroristic threat);
- Section 33.021, Penal Code (online solicitation of a minor);
- Section 34.02, Penal Code (money laundering);
- Section 35A.02 Penal Code (Medicaid fraud);
- Section 42.09, Penal Code (cruelty to animals);
- An offense under Chapter 31, Penal Code(theft) punishable as a felony if the conviction is less than 5 years;
- An offense under Texas Penal Code Title 5, Title 7, Title 9, Title10 or Title 4 section (A)-(T) or
- A conviction under the law of another State, Federal Law, or the Uniform Code of the Military Justice for an Offense containing elements that are substantially similar to the elements of an offense listed under the codes stated above.
- The Agency reserves the right to determine if any offense committed that is not listed above, would be a contraindication to employment, therefore resulting in termination or non-offer of employment.

I, _____, have been informed that a criminal history
(Print Name)
Check may be performed on my name as mandated by Chapter 250 of the Health and Safety Code. I Certify that I have not been convicted of any offense that would bar employment as listed above, and that I have informed this Agency of all names (i.e. maiden, aliases) that I have used in the past. I understand That my employment is conditional upon the satisfactory completion of the required background screening and inquiry of the Employment Misconduct Registry and or Nurses Aide Registry. I further understand That should I be arrested and convicted of any of the above listed violations, I will report this to the Agency immediately and that my services may be terminated at that time.

Please list all other names you are known by:

_____ _____

SSN: _____-_____-_____

Signature of Applicant: _____ Date: _____/_____/_____

TEXAS
Department of Aging and Disability Services

DADS has issued the following Provider Alert(s):

PERSONAL ATTENDANT WAGES INCREASE SEPT. 1, 2019

On Sept. 1, 2019, providers must begin paying employed or contracted personal attendants who work in the following programs at least $8.11, up from the current $8 per hour minimum:

> in the CLASS Program:
- habilitation (transportation);
- Community First Choice Personal Care Services/Habilitation (CFC PAS/HAB); and
- in-home respite;

> in the Deaf Blind Multiple Disabilities (DBMD) Program:
- residential habilitation (transportation)
- CFC PAS/HAB; and
- in-home respite;

> in the Home and Community-based Services (HCS) Program:
- supported home living (transportation);
- CFC PAS/HAB; and
- in-home respite; and

> in the Texas Home Living (TxHmL) Program:
- community support (transportation);
- CFC PAS/HAB; and
- in-home respite.

Newly employed or contracting attendants hired on or after Sept. 1, 2019, must be notified of the required base wage level within 3 days of being hired.

Providers are required to comply with the requirements outlined in this information letter effective September 1, 2019.

Employee Name: _____ Signature: _____

Date: _____

Pledge for Confidentiality of Protected Personal Health Information

I, the undersigned, have read and understand **ASSURANCEJ HOMECARE SERVICES, INC.'s** policy on Confidentiality of Protected Personal Health Information in consideration of my employment or association with **ASSURANCEJ HOMECARE SERVICES, INC.** and as an integral part of the terms and conditions of my employment or association, I hereby agree that I will not at any time during my employment or after my employment or association ends, access or use personal health information, or reveal or disclose to any person within or outside **ASSURANCEJ HOMECARE SERVICES, INC.** any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable legislation and corporate and departmental policies governing proper release of information. I also understand that unauthorized use or disclosure of such information will result in disciplinary action up to and including termination of employment, contract, or association and the imposition of fines pursuant to applicable state and federal laws.

_____/_____/_____
Date

_____
Name of Individual Making Pledge

_____
Signature of Individual Making Pledge

_____
Department

I have discussed the Confidentiality Protected Personal Health Information Policy and the Consequences of a breach with the above named.

_____
Name of Individual Administering Pledge

_____
Signature of Individual Administering Pledge

_____/_____/_____
Date