Care on Wheels Homecare Services

3300 Bass Lake Road Ste 506, Brooklyn Center, MN 55429
Tel: 763-566-3038| Fax: 763-566-3029

Employment Application

Applicant Information

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

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: ( )_____ E-mail Address: _____

Date Available: _____ Social Security No.: ___-___-____ Desired Salary: $_____

Position Applied for: _____

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: _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

References

Please list two professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: ( )_____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: ( )_____

Address: _____

Previous Employment

Company: _____ Phone: ( ) _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: $_____ Ending Salary: $_____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your this employer 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 authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for rejection or dismissal. I authorize Care on Wheels Homecare to submit a background study to the Minnesota Department of Human Service (see PCA application and background study notice). I understand that a background study disqualification by DHS will prevent me from being employed by the company. Further, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time, with or without cause, and with or without any prior notice. I hereby agree that, as a condition of employment by the Agency, I will promptly inform the Agency in writing of any criminal convictions, in any jurisdiction (including all pleas of guilty), other than minor traffic offenses, of which I am convicted after today.

Signature: _____ Date: _____

Minnesota Department of **Human Services**

DHS-4469-ENG 11-16

Minnesota Health Care Programs (MHCP)

Individual PCA Enrollment Application

Complete this form online, print and then fax to MHCP. Complete at least all bolded fields to enroll an individual PCA. We will return incomplete forms to you.

◯ New hire (requires new background study and completion of PCA training)

◯ Rehire (requires new background study and completion of PCA training)

◯ Previously used for managed care organization (MCO) claims only (new background study not required)

Individual PCA Information

PROVIDER TYPE	LEGAL NAME (FIRST)	FULL MIDDLE NAME	LAST NAME	SOCIAL SECURITY NUMBER
38 – INDIVIDUAL				

ADDRESS (RESIDENTIAL ADDRESS ONLY – DO NOT ENTER A PO BOX)	CITY	STATE	ZIP CODE

COUNTY OF RESIDENCE	PHONE NUMBER	DATE OF BIRTH	UMPI (if requesting reinstatement)

INDIVIDUAL PCA TRAINING	Is the individual 18 years old or older?
DATE PASSED: _____ CERTIFICATION NUMBER: _____	◯Yes ◯No* *May affiliate with only one agency

If previously used for MCO only claims, has this individual maintained continuous employment with your agency? ◯Yes ◯No	BGS NUMBER or APPLICATION ID

Individual PCA Provider Statement

I have reviewed and certify the information provided above is true and correct to the best of my knowledge. **I will notify the Minnesota Department of Human Services Provider Enrollment of any additions or changes to the information.**

By signing this form, I acknowledge I have read and understand the Application and Background Study Privacy Notice. I also authorize the Minnesota Department of Human Services to use the information collected about me according with the Privacy Notice.

NAME OF PCA (print or type)	SIGNATURE OF PCA	DATE SIGNED

Group Affiliation Information

You have the option to affiliate or enroll the individual PCA named above, if 18 years old or older, with other agencies you directly own without completing another application and agreement. Do you want to affiliate the above named individual PCA with any other agencies you own? ◯Yes ◯No

Agency Information

AGENCY NAME	AGENCY NPI OR UMPI	AGENCY FAX NUMBER
Care On Wheels Homecare Services, LLC	A812675000	763-566-3038

AGENCY PERSONNEL COMPLETING FORM	AGENCY SIGNATURE

Next Steps

Read, sign and date the MHCP Provider Agreement - Support Worker (PCA, CDCS and CSG) (DHS-4611), and return it with this application.

Fax the application and agreement to 651-431-7465. Only faxed requests will be processed.

Minnesota Department of **Human Services**

DHS-4611-ENG 4-15

Minnesota Health Care Programs

Provider Agreement – Individual Support Worker (CDCS, CSG, PCA)

As a participating provider in health service programs administered by the Minnesota Department of Human Services (the Department), the Provider agrees to:

A. Submit documentation to your affiliated agency that fully discloses the extent of services provided to individuals under these programs. The documentation must be legible and meet the requirements of Minnesota Statutes Section 256B.0659, subdivision 12 for all individual support workers in CDCS, CSG, and PCA.

B. Furnish the Department, the Secretary of the U.S. Department of Health and Human Services (DHHS), or the Minnesota Medicaid Fraud Control Unit with such information as it may request regarding payments claimed for services provided under these programs.

C. Comply with all federal and state statutes and rules relating to the delivery of services to individuals and to the submission of claims for such services.

D. Accept as payment in full, amounts paid in accordance with schedules established by the Department, except where payment by the recipient has been authorized by the Department.

E. Make full disclosure of any convictions(s) of program crimes as required by 42 C.F.R. § 455.106.

F. Comply with all federal statutes, implementing regulations and guidance prohibiting discrimination on the basis of race, color, national origin, sex, age, religion and disability in any program or activity receiving federal financial assistance from DHHS; and to comply with the Minnesota Human Rights Act.

G. Render to recipients services of the same scope and quality as would be provided to the general public, within Minnesota Health Care Programs (MHCP) guidelines.

H. Comply with the provisions of any fully executed agreement and/or addendum required by the Department, which is incorporated herein by reference.

I. Comply with the advance directive requirements as required by 42 C.F.R. §§ 489.100 and 417.436.

J. Properly handle and safeguard protected information collected, created, used, maintained, or disclosed on behalf of the Department. For purposes of this Agreement, "protected information" means data subject to any of the following laws:

1. The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes Chapter 13, in particular § 13.46 ("welfare data");
2. The Minnesota Health Records Act § 144.291 and § 144.298;
3. The Health Insurance Portability and Accountability Act ("HIPAA"), including but not limited to the requirements of the Privacy Rule and the Security Regulations, 45 C.F.R. Part 160 and Part 164, subparts A and E.
4. Federal law and regulations that govern the use and disclosure of substance abuse treatment records, 42 U.S.C.S. § 290dd-2 and 42 C.F.R. § 2.1 to § 2.67; and
5. Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

	DIRECT SUPPORT WORKER INITIALS
NAME OF SUPPORT WORKER	UMPI

K. Comply with the laws described in section J. This includes the Provider:

1. Not using or further disclosing protected information created, collected, received, stored, used, maintained or disseminated in the course or performance of this Agreement other than as necessary to perform its obligations under this Agreement, or as required by law, either during the period of this Agreement or hereafter. See, respectively, 45 C.F.R. §§ 164.502(b) and 164.514(d), and Minn. Stats. § 13.05 subd. 3.

2. Using appropriate administrative, physical, and technical safeguards to prevent use or disclosure of the protected information other than as provided for by this Agreement and to ensure the confidentiality, integrity, and availability of any electronic protected health information (PHI) that it creates, receives, maintains, or transmits on behalf of the Department. Provider will not transmit PHI over the Internet or any other unsecure or open communications channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 C.F.R. § 164.312. If the Provider stores or maintains PHI in encrypted form, the provider shall, at the Department's request, promptly provide the Department with the key or keys to decrypt such information. The Provider shall not forward previously encrypted data to any other party, unless otherwise required by this Agreement.

3. Mitigating, to the extent practicable, any harmful effects known to the Provider of a use, disclosure, or breach of security with respect to protected information by the Provider in violation of this Agreement.

L. Agree that this Agreement may be immediately terminated at the discretion of the Department if it determines that the Provider has violated a material term of the Agreement, including but not limited to, non-compliance by the Provider with the HIPAA Privacy Rule and Security Standards. If termination is not feasible, the Department shall report the breach to the Secretary of DHHS.

Upon termination of this Agreement, all of the protected information provided by the Department to Provider, or created or received by the Provider on behalf of the Department, that the Provider still maintains in any form, including information that is in the hands of subcontractors or agents of the Provider, shall be destroyed or returned to the Department, and the Provider shall retain no copies of such information. If it is infeasible to return or destroy the information, the Provider shall provide the Department notification of the conditions that make return or destruction infeasible, and shall extend the protections of this Agreement to such information and limit further use and disclosure of such information to those purposes that make return or destruction infeasible, for as long as the Provider maintains the information.

M. Agree that any ambiguity in this Agreement shall be resolved to permit the Department to comply with HIPAA, MDGPA, and other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information and other state and federal laws and regulations.

Upon signature, this Provider Agreement supersedes and replaces all former Provider Agreements the Provider has with the Department.

An individual applicant must personally sign the Provider Agreement. Please sign and date below, initial page 1, and return both page 1 and page 2 of this agreement. **Please retain a copy of the provider agreement for your files, and return the original to the Department of Human Services.**

NAME OF SUPPORT WORKER (TYPE OR PRINT)	TITLE
SIGNATURE OF SUPPORT WORKER	DATE

Please return page 1 and page 2 of this document

Care on Wheels Homecare Services, LLC

Employee Authorization to Release References

I acknowledge that I have been informed that it is Care on Wheels Homecare Services, LLC general policy to respond to a prospective employer's request only three items of information about current or former employees:

1) The dates of employment
2) Description(s) of the job(s) performed
3) Starting and ending salary or wage rates

I have voluntarily signed this release and asked that Care on Wheels Homecare Services, LLC depart from their regular policy on responding to reference requests from any prospective employer that may be considering me for employment.

I authorize Care on Wheels Homecare Services, LLC to advise those prospective employers on any employment-related information that Care on Wheels Homecare Services, LLC in its sole discretion and judgment, may consider appropriate to disclose, including any personal comments, evaluations, or assessments that Care on Wheels Homecare Services, LLC may have about my performance or behavior while I was employed.

In exchange for Care on Wheels Homecare Services, LLC agreement to depart from its general policy and to disclose additional employment related information pursuant to my request, I agree to release and discharge Care on Wheels Homecare Services, LLC and Care on Wheels Homecare Services, LLC's successors, employees, officers, and directors from all claims, liabilities, and causes of action, known or unknown, fixed or contingent, that arise from or that are in any manner connected to Care On Wheels Homecare Services disclosure of employment related information to prospective employers. This release includes, but is not limited to – claims of defamation, libel, slander, negligence, or interference with contract or profession.

I acknowledge that I have carefully read and fully understand this release. I further acknowledge that I was given the opportunity to consult with an attorney before signing this release and that I signed this release voluntarily and without coercion or duress by any person.

This release sets forth the entire agreement between Care on Wheels Homecare Services, LLC and me, and I acknowledge that I have not relied upon any representation or statement, written o oral, not set forth in this document.

Signature: _____ Date: _____

Print Name: _____ Date: _____

PCA Agency Disclosure & Release

Cares on Wheels Homecare Services, LLC employees are required to disclose the names of any other PCA agencies they currently work for and authorize the company to contact them regarding your hours worked. **PCAs cannot work more than 275 hours per month. If you work for multiple consumers/agencies your combined totals cannot exceed this limit.** (Minn. Stat. Chapter 245A, Minn. Stat.§252A.02, subd. 3a, Minn. Stat. §256B.0659, subd. 11)

It is the PCAs responsibility to:

1. Monitor and record their number of hours worked (monthly combined totals with all consumers/agencies).
2. Notify their consumer(s) and *COW* regarding total hours worked each week with all consumers/agencies.
3. Sign a PCA Agency Disclosure & Release for each PCA agency they actively work for or are hired with in the future and notify *COW* immediately of changes in their working status as a PCA.
4. Return any received wages for hours worked that exceeded the limits mentioned above, as the hours are not authorized and thus are ineligible to accept wages for.

PCA Name:

Initial below:

_____ **I am NOT currently working as a PCA for any other agencies.** I agree to inform my consumer and Care on Wheels if I am employed as a PCA for any other consumers or agencies in the future and I will complete a new copy of this disclosure at that time.

_____ **I AM currently working as a PCA for another agency which I have listed below.** I authorize Care on Wheels and my employer listed below to communicate with each other and share pertinent information regarding my work schedule, daily/weekly/monthly total hours worked and share copies of my timesheets when necessary. I also agree to inform my consumers and Care on Wheels if I am employed as a PCA for any other consumers or agencies in the future and I will complete a copy of this disclosure for each agency at that time.

Agency Name: _____

Supervisor Name: _____

Phone #: Fax #: _____

Number of Consumers/Clients currently working with: _____

Average Weekly Total Hours: _____ Average Monthly Total Hours: _____

X_____ **Date:** _____

PCA Signature

Care on Wheels Home Care Services, LLC
3300 Bass Lake Road Ste 506
Brooklyn Center, MN 55429
Tel: 763-566-3038 | Fax: 763-566-3029

TB Test Verification Form

If TB test is done off campus, this form is to be completed by medical personnel

and fax to our office at : Attn: Miata -763-566-3029

This is to certify that _____, SS # _____ is free of tuberculosis in a communicable form.

This certification is based on (Please attached results):

_____(a) Negative TB symptoms screening on _____. (Must be completed)

_____.(b) PPD one-step given on _____ and read on _____ results _____ mm.

_____ (c) PPD two-step given on _____, and read on _____ results _____ mm.

given on _____ and read on _____ results _____ mm.

_____ (d) Chest x-ray taken on _____ (date), and copy of x-ray results attached.

Signed by: _____ Date _____
RN or Physician Signature

Care on Wheels Home Care Services, LLC
Tel: 763-566-3038 | Fax: 763-566-3029

Training Acknowledgement

This to acknowledge that a Care on Wheels Homecare Services, LLC representative oriented me to the below listed training, and by initialing below, I acknowledge that I have demonstrated competence in the following areas:

_____ Fraud Prevention

_____ Timesheet completion

_____ Grievance Policy

_____ Emergency & Safety procedures

_____ Quality Assurance Practices

_____ Overview of company's policies and procedures

Name: _____

Signature: _____ Date: _____