REST ASSURE HOME CARE

EMPLOYMENT APPLICATION FOR HOME CARE WORKER

Personal Information	
Name	First: _____ 2nd Initial: _____ Last: _____
Address	Street: _____ Apartment: _____ City: _____ State: _____ Zip: _____
Phone	Home: _____ Cell: _____ Other: _____
Email	Email: _____
DOB	Day: _____ Month: _____ Year: _____
SSN	Social Security Number: _____
Gender	Male: _____ Female: _____
Language	What languages do you speak?: _____ _____
Emergency Contact	Name & Phone Number of person to contact in the event of an emergency: Contact Name 1: _____ Relationship: _____ Address: _____ Phone #: _____ Contact Name 2: _____ Relationship: _____ Address: _____ Phone #: _____

Employment Eligibility	
	Are you eligible to work in the United States? ☐ Yes ☐ No If no specify: _____ Have you been convicted of or plead nolo to a felony in past 10 years? ☐ Yes ☐ No If yes specify: _____

Medical Information				
Allergies	Allergies:	☐ Yes	☐ No	If no specify:
	Seizures:	☐ Yes	☐ No	If no specify:

REST ASSURE HOME CARE

PRE-EMPLOYMENT BACKGROUND CHECK AUTHORIZATION

I, _____ , understand that as part of the employment process, Rest Assure Home Care needs to complete a background check on me regarding:

1. Criminal record
2. Sex and violent offenders record
3. Employment verification
4. Education verification
5. License verification
6. Motor vehicle records
7. Personal/professional reference verification
8. Medical suitability
9. Drugs
10. Child abuse, if indicated

- I authorize all federal and state agencies, persons and organizations that may have information relevant to this research to disclose such information to Rest Assure Home Care or it's authorized agent(s).
- I understand that this authorization is to be part of the written and signed employment application.
- I also understand that I do not have to give authorization for a background check but if I don't give permission, my employment application will not be processed further.
- I understand that I have specific rights under the federal Fair Credit Reporting Act (FCRA) and may have additional rights under relevant State law.
- I further authorize that a photocopy of this authorization may be considered as valid as the original.
- I hereby certify that all statements on this form are true and correct to the best of my knowledge and belief. I understand that employment with Rest Assure Home Care is contingent upon successful completion of a background check.

_____ _____ _____

Signature Date Phone No.

Full Name: _____

Former Name(s) and Date(s) used:

_____

Current Address:

_____

JOB DESCRIPTION: COMPANION SITTER

The person to fill this position requires the ability to read, write and follow instructions. Also, the individual must complete training or pass competency assessment, as appropriate, for understand the needs of population served.

Responsible to:

- Governing Body, On-Site Manager/Administrator/Home provider, Director and Supervisor.

Education and Experience:

- Experience or related experience
- Must be 21 years of age
- Current valid driver's license
- Current CPR/First Aid Certificate
- Current Physical Examination
- Current Negative TB Screen
- Satisfactory Fingerprint and Criminal Record Check

Duties and Responsibilities:

The job duties pertaining to this position entails the following tasks:

- Basic meal preparation
- Provision of transportation services; escort
- Housekeeping
- Home safety
- Handling emergencies
- Infection control

Employee Signature: _____

Date: _____

Administrator's Signature: _____

Date: _____

JOB DESCRIPTION FOR REGISTERED NURSE

Name: _____

Position: Nurse

Qualifications

- Georgia License Registered Nurse
- First Aid/CPR
- BLS Certified
- Signed statement of history of no misconduct
- Clean criminal background check
- Negative TB test
- Completion of orientation training
- Ability to read and write in English
- Ability to follow verbal and written instructions

Duties and Responsibilities:

- Take verbal orders
- Participation in the development and implementation of the service plan for clients receiving nursing services
- Regularly assess the needs of clients receiving nursing services
- Medication administration teaching
- Monitoring medication
- Complete service plans
- Supervise CNAs, PCAs and nurses
- Train new staff/conduct orientation training
- Supervise management of records
- Investigate incidents/accidents/grievances

Employee Signature: _____

Date: _____

REST ASSURE HOME CARE

I acknowledge that:

1. I understand that it is my legal and ethical responsibility to protect the security, privacy, and confidentiality of all client records, Agency information and other confidential information relating to the Agency, including business, employment and medical information pertaining to clients, their families and employees.
2. I will only discuss confidential information during the performance of my duties and only for job related purposes and shall take caution to ensure such conversations are not within hearing range of anyone who is not entitled to have this information
3. I shall respect and maintain the confidentiality of all discussions, conversations, and any other information generated while providing service to clients in connection with individual client service, risk management and/or peer review activities.
4. I shall not disclose the content of any discussions, deliberations, client records, peer reviews or risk management information, except to persons authorized to receive such information, while conducting Agency business.
5. I shall only access or distribute client care information when executing my job duties or when required to do so by law.
6. I will only access records on a "need-to-know" basis in the performance of my duties.
7. I will not share my Login or User ID and password for accessing electronic records with anybody. If I believe someone else has used my Login or User ID and/or password, I will immediately notify the Supervisor.
8. I will only use mobile computing devices, with Agency approval, AND providing they are encrypted with an approved data encryption solution before using them for any Agency-related business. I understand that I may be personally responsible for any breach of confidentiality resulting from unauthorized access due to hacking or other means to Agency information stored on my unencrypted device
9. I understand that the Agency will undertake measures to determine if client and employee records have been accessed without authorization.
10. I understand that state and federal laws/regulations governing a client's right to privacy, the illegal or unauthorized access or disclosure of client's confidential information may result in disciplinary action up to and including immediate termination from my employment and possible civil fines and criminal sanctions.
11. I understand that I am obligated to maintain these confidentialities after my employment with this Agency ceases.

I hereby acknowledge that I have read and understand the above-mentioned information and that my signature below indicates my agreement to comply with these terms.

Signature _____ Date _____

Administrator's or Representative's Name

Administrator's or Representative's Signature

Date: _____

Caregiver's Name

Caregiver's Signature

Date: _____

HEPATITIS EXPOSURE REPORTING

IF AN EXPOSURE OCCURS

What should I do If I am exposed to the blood of a patient?

Immediately following an exposure to blood: Wash needlesticks and cuts with soap and water. Flush splashes to the nose, mouth, or skin with water, irrigate eyes with clean water, saline, or sterie irrigates. No scientific evidence shows that using antiseptics or squeezing the wound will reduce the risk of transmission of a bloodborne pathogen. Using a caustic agent such as bleach is not recommended.

Report the exposure to the agency and/or department (e.B., occupational health, infection control) responsible for managing exposures. Prompt reporting is essential because, in some cases, post exposure treatment may be recommended, and it should be started as soon as possible. Discuss the possible risks of acquiring HBV, HV, and HIV and the need for post exposure treatment with the provider managing your exposure. You should have already received hepatitis B vaccine, which is extremely safe and effective in preventing MBV infection.

It is the obligation of all Rest Assure Home Care LLC employees to report known exposure to tuberculosis AND hepatitis.

_____ _____

Signature Date

TB Exposure Reporting: *What to Do If You Have Been Exposed to TB*

You may have been exposed to TB bacteria if you spent time near someone with TB disease. The TB bacteria are put into the air when a person with active TB disease of the lungs or throat coughs, sneezes, speaks or sings. You cannot get TB from:

- clothes
- drinking glass
- eating utensils
- handshake
- toilet
- other surfaces

If you think you have been exposed to someone with TB disease, you should contact your doctor or local health department about getting a TB skin test or a special TB blood test immediately. Be sure to tell the doctor or nurse when you spent time with the person who has TB disease.

It is important to know that a person who is exposed to TB bacteria is not able to spread the bacteria to other people right away. Only persons with active TB disease can spread TB bacteria to others. Before you would be able to spread TB to others, you would have to breathe in TB bacteria and become infected. Then the active bacteria would have to multiply in your body and cause active TB disease. At this point, you could possibly spread TB bacteria to others.

People with TB disease are most likely to spread the bacteria to people they spend time with every day, such as family members, friends, coworkers, or schoolmates.

Some people develop TB disease soon (within weeks) after becoming infected, before their immune system can fight the TB bacteria. Other people may get sick years later, when their immune system becomes weak for another reason. Many people with TB infection never develop TB disease.

It is the obligation of all Infiniti Rest Assure Home Care LLC employees to report known exposure to tuberculosis AND hepatitis.

Signature _____ Date _____

CONFIDENTIALITY & NON-DISCLOSURE AGREEMENT

It is the responsibility of all Agency employees to preserve and protect confidential Agency, client and employee medical, personal and business information and, thus, shall not disclose such information except as authorized by law, client or individual.

Confidential Client Information includes, but is not limited to any identifiable information about a client's and/or his/her family including, but not limited to:

- medical history;
- mental, or physical condition;
- treatments and medications;
- test results;
- Conversations;
- financial information; and,
- household possessions.

Confidential Employee information includes, but is not limited to:

- contact information i.e. telephone number(s); address, email address;
- names of spouse and/or other relatives;
- Social Security Number;
- performance appraisal information;
- health status and treatments; and,
- other information obtained from their personnel files which would be an invasion of privacy e.g.:
  - Date of Birth;
  - Place of Birth
  - Traditional password identifiers
  - Bank account numbers
  - Income tax records
  - Driver's license numbers
  - Credit card numbers
  - Passport numbers

<u>Confidential Business Information</u>

Confidential business information includes, but is not limited to:

- client lists;
- Security data and credentials such as passwords,
- any information that, if released, could be harmful to the Agency; and,
- any financial information including accounts receivable, accounts payable and payroll.

CREDIBILITY STATEMENT

I, _____ , have never been shown by credible evidence (e.g. court or jury, a department investigation or other reliable evidence) to have abused, neglected, sexually assaulted exploited or deprived any person or to have subjected any person to serious injury as a result of intentional or gross negligent misconduct.

_____ _____

Employee's Signature Date

_____ _____

agency Representative and Title Date

REST ASSURE HOME CARE

Date of Birth: _____ Social Security Number: _____

Current Driver's License: _____ State: _____

List any other cities, states and dates of residency during the last 10 years (Use back of sheet if necessary).

City	State:	From: Month/Year	To: Month/Year

REST ASSURE HOME CARE

Education

Formal

Diploma: _____

Certificate: _____

Degree: _____

Other: _____

Other: _____

Informal

Do you have current First Aid Certification (State Level): _____ Expiry Date: _____

Do you have current CPR? _____ Expiry Date: _____

Have you taken a Food Safety course? _____

Other: _____

Other: _____

Restrictions

Work Limitations

List any work limitations that you may have and briefly describe:

Hearing:	_____ Yes	_____ No	_____	
Speech:	_____ Yes	_____ No	_____	
Lifting:	_____ Yes	_____ No	_____	
Health:	_____ Yes	_____ No	_____	
Physical:	_____ Yes	_____ No	_____	
Emotional:	_____ Yes	_____ No	_____	
Other:	_____ Yes	_____ No	_____	

Availability for Work

Hours & Days Available for Work

_____ Full-time _____ Part-time _____ Short-notice _____ Split Shift

_____ Sunday	From: _____	To: _____	
_____ Monday	From: _____	To: _____	
_____ Tuesday	From: _____	To: _____	
_____ Wednesday	From: _____	To: _____	
_____ Thursday	From: _____	To: _____	
_____ Friday	From: _____	To: _____	
_____ Saturday	From: _____	To: _____	

Minimum numbers of hours you will work in one day? _____

Maximum numbers of hours you will work in one day? _____

What is your start availability date? _____

REST ASSURE HOME CARE

Type of Work Seeking	
Type of Position(s) Preferred	_____ Companion ____ Personal Care Aide(PCA) ____ CNA ____ LPN ____ RN _____ Live-in Other: _____ Live-in care usually requires you to be in a client's home continuously for 3-4 days at a time every week. Indicate which shifts you will accept: ____ Weekdays (Mon a.m. to Fri a.m. ____Weekends (Sun a.m. to Mon a.m.
Clients Not Willing/Able to Work With	_____ Dementias/Alzheimer's _____ Smokers _____ Mental Retardation _____ Behavioral Disorders _____ Elderly (over 65) _____ Children _____ Other: _____ _____ Physical Disabilities _____ Pets _____ Females _____ Males _____ Client use of marijuana for medicinal purposes _____ HIV Positive/Aids
Duties Not Willing/Able to Perform	_____ Bathing _____ Grooming _____ Oral Care _____ Dressing _____ Bowel Care _____ Bladder Care _____ Feeding _____ Ambulation _____ Housekeeping _____ Laundry _____ Meal Preparation _____ Shopping _____ Transportation _____ Medication Reminding _____ Friendly Reassurance Phone Call/Home Visit _____ Other: _____
Experience	Indicate which of the following you have experience in: _____ Bathing/Showering _____ Grooming _____ Personal Hygiene _____ Dressing _____ Bowel Care _____ Bladder Care _____ Feeding _____ Ambulation _____ Toileting _____ Housekeeping _____ Laundry _____ Meal Preparation _____ Shopping _____ Transportation _____ Medication Reminding _____ Friendly Reassurance Phone Call/Home Visit _____ Socialization _____ Other: _____
Assignment Location	Are you restricted in the geographical location you are willing/able to work? ☐ Yes ☐ No Explain: _____

Employment Eligibility	
Type	_____ Private Vehicle ____ Bus ____Bike ____ Other:
Driver's License	Do you have a valid Driver's License? _____

REST ASSURE HOME CARE

Transporting Clients	Are you willing to transport clients in your private vehicle? _____ Do you have adequate vehicle insurance? _____ Are you willing to drive a client's vehicle? _____ Are you willing to escort a client in their own vehicle? _____ Are you willing to escort a client on public transportation? _____ Comments: _____
Abuse Investigation	
	Have you ever been investigated for abuse, neglect or domestic violence? if "yes", explain: _____ Yes _____ No _____ _____
Reference Information - 5 Years absent of resume Attach additional sheet of paper for additional references	
Work Related #1 (Last Position)	Company Name: _____ Address: _____ Phone No./Email Address: _____ supervisor's Name: _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Work Related #2 (2nd Last Position)	Company Name: _____ Address: _____ Phone No./Email Address: _____ supervisor's Name: _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Work Related #3 (3rd Last Position)	Company Name: _____ Address: _____ Phone No./Email Address: _____ supervisor's Name: _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____

REST ASSURE HOME CARE

Work Related #4 (4th Last Position)	Company Name: _____ Address: _____ Phone No./Email Address: _____ supervisor's Name: _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Work Related #5 (5th Last Position)	Company Name: _____ Address: _____ Phone No./Email Address: _____ supervisor's Name: _____ Position Held: _____ Length of Employment: _____ Reason for Leaving: _____
Personal #1	Name: _____ Address: _____ Phone No./Email Address: _____ Nature of Friendship *(friend, co-worker, family, etc)* _____ (Other than relative)
Personal #2	Name: _____ Address: _____ Phone No./Email Address: _____ Nature of Friendship *(friend, co-worker, family, etc)* _____ (Other than relative)

I certify that, to the best of my knowledge, the answers given are true and complete and that are purposeful misrepresentation may result in rejection of my application. I authorize investigation of all statements contained in this application, as required. Additionally, I authorize former employers, references and any other individual/organizations to provide information to Rest Assure Home Care, LLC and I hereby release and discharge any of the above and Rest Assure Home Care, LLC from any liability of any kind or nature. I also understand that it is my responsibility to keep such information current and accurate by updating it as often as necessary.

I agree to a physical examination, if requested and understand that failure to meet any medical and/or health requirements for the position may prevent my employment with the Agency. I also understand that employment, for certain positions, may be conditional upon successful completion of a substance abuse screening test and a criminal background check.

If further understand that, if hired, I may be required to provide proof that I am a citizen of the United States or proof that I am currently authorized to work in the United States.

_____ _____

Applicant's Signature Date

REST ASSURE HOME CARE

DOCUMENTATION OF ORIENTATION

Date	Hours	Instructor's Initials	Topics
			SCOPE OF SERVICES
			TYPES OF SERVICES OFFERED
			CLIENT'S RIGHTS & RESPONSIBILITIES
			COMPLAINTS & RESOLUTIONS
			JOB DESCRIPTION & RESPONSIBILITIES
			INFECTION CONTROL
			REPORTING EXPOSURE TO TB, HEPATITIS & OTHER COMMUNICATIVE DISEASES
TOTAL HRS 2			
Date	Hours	Instructor's Initials	Topics
			REPORTING CLIENT PROGRESS & PROBLEMS
			PROCEDURES FOR HANDLING EMERGENCIES
			PROCEDURE FOR HANDLING INCIDENTS THAT AFFECT DELIVERY OF SERVICES
			CLIENT SERVICE PLAN AND RIGHTS
TOTAL HRS 4			
Date	Hours	Instructor's Initials	Topics
			HOME CARE AGENCY WRITTEN POLICY & PROCEDURES
			UNDERSTANDING CARE PLAN
			SKILLS INVENTORY
			DEMO OF TASK COMPLETED
			BLOOD BORNE PATHOGENS
			BACK SAFETY
			VISIBLE SIGNS OF ILLNESS
			VITAL SIGNS
			NUTRITION

Employee Signature: _____ Date: _____

Agency Trainer Signature: _____ Date: _____

REST ASSURE HOME CARE

Caregiver Name:_____

A	=	PROFICIENT (EXPERT)
B	=	EXPERIENCED (PERFORMS INDEPENDENTLY)
C	=	FAMILIAR (MAY REQUIRE ASSISTANCE)
D	=	NO EXPERIENCE (TRAINING NEEDED)

ACTIVITY			SKILL LEVEL				COMMENTS/ ACTION PLAN
			A	B	C	D	
1.	Taking Rectal, Oral, Axillary Temp (Digital Thermometer						
	a.	Rectal 99.6F					
	b.	Oral 98.6F					
	c.	Axillary					
2.	Taking Pulse(Radical)able to locate pedal, carotid						
3.	Counting Respirations						
4.	Blood Pressure						
	a.	with stethoscope					
	b.	without stethoscope					
5.	Bed Bath						
	a.	Correct order followed					
	b.	Temperature of water appropriate					
	c.	Soap rinsed off thoroughly					
	d.	Skin dried thoroughly					
	e.	Lotion applied appropriately					
	f.	Client dressed including hair combed					
	g.	Client kept warm throughout					

REST ASSURE HOME CARE

A	=	PROFICIENT (EXPERT)
B	=	EXPERIENCED (PERFORMS INDEPENDENTLY)
C	=	FAMILIAR (MAY REQUIRE ASSISTANCE)
D	=	NO EXPERIENCE (TRAINING NEEDED)

ACTIVITY			SKILL LEVEL				COMMENTS/ ACTION PLAN
			A	B	C	D	
6.	Sponge/Tub/Shower Bath						
	a.	Rectal 99.6F					
	b.	Oral 98.6F					
	c.	Axillary					
7.	Shampoo in Sink/Tub/Bed						
	a.	Position client appropriately					
	b.	Protect client's clothing from getting wet					
	c.	Avoid getting water and shampoo in client's face					
	d.	Rinse and dry client's hair					
	e.	Comb client's hair					
	f.	Keep client warm and comfortable throughout					
8.	Nail Care						
	a.	Clean client's nails properly and gently with proper tools, brush and orange sticks					
	b.	Temperature of water appropriate					
	c.	Soap rinsed off thoroughly					
	d.	Skin dried thoroughly					
9.	Skin Care						
	a.	Observe skin condition					
	b.	Apply lotion to client's skin					
	c.	Massages boney prominences and reddened areas					
	d.	Ensures linens are wrinkle free					

A	=	PROFICIENT (EXPERT)
B	=	EXPERIENCED (PERFORMS INDEPENDENTLY)
C	=	FAMILIAR (MAY REQUIRE ASSISTANCE)
D	=	NO EXPERIENCE (TRAINING NEEDED)

ACTIVITY			SKILL LEVEL				COMMENTS/ ACTION PLAN
			A	B	C	D	
10.	Accucheck Assistance						
	a.	Washes hands					
	b.	knows normal range for blood sugar					
	c.	Knows actions to take for abnormal blood sugar					
	d.	Understands instances in which an error message might be received and what the error message means.					
11.	Provide Oral Hygiene as appropriate for each client						
	a.	Washes client's dentures					
	b.	Brushes client's teeth or offers clients the necessary supplies to brush his or her teeth					

A	=	PROFICIENT (EXPERT)
B	=	EXPERIENCED (PERFORMS INDEPENDENTLY)
C	=	FAMILIAR (MAY REQUIRE ASSISTANCE)
D	=	NO EXPERIENCE (TRAINING NEEDED)

ACTIVITY			SKILL LEVEL				COMMENTS/ ACTION PLAN
			A	B	C	D	
12.	Toileting						
	a.	Proper positioning, use of bed pan and emptying					
	b.	Proper positioning, use of urinal and emptying					
	c.	Provide privacy when needed to the client					
	d.	Catheter care - measure intake and output					
	e.	Bowel elimination procedure digital, manual stimulation					
	f.	Bladder elimination procedures for straight catheter insertion, condom catheter care and care of indwelling catheter					
	g.	Ability to identify associated signs and symptoms of potential infection related to bladder care					
13.	Safe Transfer Techniques & Ambulation						
	a.	Uses good body mechanics to prevent injury					
	b.	Makes environment safe for ambulation					
	c.	Locks wheels on wheelchair and beds as needed					
	d.	Ensures client wears non-skid footwear					
	e.	Use of gate belt correctly, as needed					
	f.	Properly supports client throughout procedure without unnecessary pulling and jerking					
	g.	Properly supports extremity during exercise					

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Non-Criminal Justice Applicant's Privacy Rights

As an applicant that is the subject of a Georgia only or a Georgia and Federal Bureau of Investigation (FBI) national fingerprint/biometric-based criminal history record check for a non-criminal justice purpose (such as an application for a job or license, immigration or naturalization, security clearance, or adoption), you have certain rights which are discussed below:

- You must be provided written notification that your fingerprints/biometrics will be used to check the criminal history records maintained by the Georgia Crime Information Center (GCIC) and the FBI, when a federal record check is so authorized.
- If your fingerprints/biometrics are used to conduct a FBI national criminal history check, you are provided a copy of the Privacy Act Statement that would normally appear on the FBI fingerprint card.
- If you have a criminal history record, the agency making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The agency must advise you of the procedures for changing, correcting, or updating your criminal history record as set forth in Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a Georgia or FBI criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the agency denies you the job, license or other benefit based on information in the criminal history record.
- In the event an adverse employment or licensing decision is made, you must be informed of all information pertinent to that decision to include the contents of the record and the effect the record had upon the decision. Failure to provide all such information to the person subject to the adverse decision shall be a misdemeanor [O.C.G.A.§35-3-34(b) and §35-3- 35(b)].

You have the right to expect the agency receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of state and/or federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

If the employment/licensing agency policy permits, the agency may provide you with a copy of your Georgia or FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, information regarding how to obtain a copy of your Georgia, FBI or other state criminal history may be obtained at the GBI website (http://gbi.georgia.gov/obtaining-criminal-history-record-information).

If you decide to challenge the accuracy or completeness of your Georgia or FBI criminal history record, you should send your challenge to the agency that contributed the questioned information. Alternatively, you may send your challenge directly to GCIC provided the disputed arrest occurred in Georgia. Instructions to dispute the accuracy of your criminal history can be obtained at the GBI website (http://gbi.georgia.gov/obtaining-criminal-history-record-information).

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

ACKNOWLEDGEMENT OF APPLICANT'S NON-CRIMINAL JUSTICE PRIVACY RIGHTS AND CONSENT TO BE INCLUDED IN THE CAREGIVER PORTAL

SECTION I – PRIVACY RIGHTS - TO BE COMPLETED BY INDIVIDUAL BEING FINGERPRINTED:

APPLICANT TYPE:
- ☐ Owner (Facility)
- ☐ Applicant for Employment/Direct Access Employee (Facility)
- ☐ Non-Employee (Facility Volunteer)
- ☐ Contractor/Direct Access (Facility)

PRINT FULL NAME _____ (Last) _____ (First) _____ (Middle) _____ (Date of Birth (mm/dd/yyyy))

Home Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

_____ (Email Address) _____ (Telephone No.)

_____ (Name of Facility)

_____ (Street) _____ (City) _____ (State) _____ (Zip)

I hereby authorize the Georgia Department of Community Health (DCH), Office of Inspector General, to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia. I understand a State and Federal fingerprint criminal background check will be conducted. By signing below, I am indicating that I have read and understand the terms and conditions of the attached Non-Criminal Justice Applicant's Privacy Rights and Policy Act Statements.

_____ (Applicant Signature) _____ (Date)

SECTION II – CAREGIVER PORTAL - TO BE COMPLETED ONLY BY AN APPLICANT OR EMPLOYEE BEING FINGERPRINTED AS PART OF FACILITY LICENSURE. DOES NOT INCLUDE OWNERS OR FAMILY EMPLOYERS.

APPLICANT TYPE
- ☐ Applicant for Employment/Direct Access Employee (Licensed Facility)
- ☐ Non-Employee (Volunteer at Licensed Facility)
- ☐ Contractor/Direct Access Employee (Licensed Facility)

The Georgia Caregiver Portal only contains the eligibility status of applicants and employees who have successfully passed the background screening process. The Caregiver Portal does not contain the names of applicants and employees who are ineligible. Family employers can access the Caregiver Portal to view a prospective applicant or current employee's eligibility to determine their suitability for employment to provide personal care services to that employer's elderly family member or wards. All services are performed at locations not licensed by DCH. Individuals should check one of the boxes below.

☐ I **agree** to the results of my background check determination being available to family employers in the Georgia Caregiver Portal.

☐ I am seeking employment only by licensed healthcare employers. I **do not want or agree** to the results of my background check determination being available to family employers.

_____ (Applicant Signature) _____ (Date)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Privacy Act Statement

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.