Care Planners INC.

when you need a helping hand

PERSONAL CARE ASSISTANT APPLICATION

Last Name **First** **Middle**

Street Address **Apt#**

City **County** **Zip**

Cell Phone **Secondary Phone**

Emergency Contact **Phone Number**

Address **Relationship to Applicant**

Email Address:____

How did you hear about the position? _____________________________________

Were you referred YES or NO If yes, by whom______________________

How many hours per week are you looking to work? __________________________

What experience have you had with disabled people either in your personal or professional life?

EDUCATION:

List High School, Vocational School, College, Name of School

WORK EXPERIENCE:

List past/current employers starting with the most recent.

Company Name____

Address____

City, State & Zip____

Supervisor Name____

Area Code & Phone #____

Position/Title_______________________ **Dates**___/___/___ **to** ___/___/___

Describe duties and responsibilities

____

____

Reason for leaving: ____

Company Name ____

Address ____

City, State, & Zip ____

Supervisor Name ____

Area Code & Phone# ____

Position/Title __________________________ **Dates** ___/___/___ **to** ___/___/___

Describe duties and responsibilities: _______________________________

____

Reason for leaving: ____

Company Name ____

Address ____

City, State & Zip ____

Area Code & Phone# ____

Position/Title _________________________ **Dates** ___/___/___ **to** ___/___/___

Describe duties and responsibilities

____

____

Reason for leaving: ____

____

____

REFERENCES:

NAME **ADDRESS** **PHONE** **RELATIONSHIP**

1.____

2.____

3.____

____ ____/____/____

Applicant Signature **Date**

Care Planners INC.

NEW LEGISLATIVE CHANGES EFFECTIVE 07/01/2009

RE: PCA'S are only allowed to work 275 hours per month

The State of Minnesota Department of Human Services (DHS) has implemented new restrictions.

The Legislators passed a law that a PCA may only work 275 hours per month. If you do work for more than one agency and go over 275 hours that month, DHS will deduct from the agencies' reimbursement, and like the State, we will only be able to pay for the hours DHS reimburses us.

If you work for another agency, you will want to keep track of your hours you work for them and the times of day that you work. You may not overlap the same working hours with another PCA if you are working for the same Client unless the Client's State Assessment clearly calls for more than one to help with transfers. "This rarely occurs!"

________________________	_____/____/____
EMPLOYEE SIGNATURE	**DATE**

____

PRINTED NAME

OVERTIME WAGE APPROVAL

Please keep in mind that overtime begins after 40 hours per week are worked. It is your responsibility to obtain approval before working any overtime hours. Must obtain approval for any overtime hours with Christopher Hanson prior to working any overtime hours.

Care Planners Inc.'s telephone numbers:

651-645-9887 (office)
651-756-9003 (after hours)

Please sign and return with packet completed to Care Planners Inc.

_______________________________________ ____/_____/_____
Care Planners Inc. Employee **Date**

(Rev 01 01 2017)

Care Planners INC.

EMPLOYEE MANUAL ACKNOWLEDEDGMENT FORM

By signing below I acknowledge that I have read a copy of Care Planners Inc's employee manual. I realize it is my responsibility to read and understand the matters set forth in this manual. The manual is a guide to Care Planners Inc's policies and procedures.

The employee handbook is designed to describe important information regarding Care Planners Inc. Any questions regarding the contents of the handbook should be directed to Chief Executive Officer of Care Planners Inc.

I have entered into my employment at Care Planners Inc voluntarily and acknowledge that there is no specific length of employment. I also acknowledge that I or Care Planners Inc may terminate my employment at will, with or without cause at any time, providing there is no violation of applicable Federal or State law.

Due to the nature of business, policies and benefits described here may change from time to time. I realize that revisions to this handbook may occur. Any notice of changes will be communicated through official notices. I acknowledge that this handbook is neither a contract of employment nor a legal document.

-- -----/-----/-----
EMPLOYEE NAME (PLEASE PRINT)

-- -----/-----/-----
EMPLOYEE SIGNATURE DATE

(Rev 01 01 2017)

If you are terminated from your position or if you leave voluntarily, any Property belonging to Care Planners Inc. or any property belonging to Clients of Care Planners Inc. must be returned to the office.

Your final check will be issued only after the property has been returned.

Applicant cannot receive Personal Care Services and be a Personal Care Attendant (PCA) within the same time period. PCA cannot be responsible party for any client receiving service under the Personal Care Program.

I acknowledge that I have received the "New Health Insurance Marketplace Coverage Options and Your Health Coverage" form/packet.

Applicant agrees to above with
Signature:________________________ Date:__/__/_____

Care Planners Inc is an Equal Opportunity Employer

Return Complete Application to
Care Planners Inc
346 Larpenteur Ave W
St. Paul, MN 551113

Must Follow I-9 rules for Identification. One from either Column A or Need Something from Column B and C
Prefer:
****Driver's License/State I.D. Card****
And
****Social Security Card****

HIPAA PRIVACY RULE

HIPAA stands for the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

The law went into effect on August 21, 1996. It is Public law 104-191

These privacy rule standards address the use and disclosure of individual's health information, called protected health information.

This rule or law assures that Client's health information is properly protected while allowing the flow of health information needed to provide health care.

Every Client receiving care from Care Planners Inc. is protected under the HIPAA law.

Any staff person who gives any medical information regarding any Client who receives services from Care Planners Inc. will be discharged immediately. HIPAA is a federal law making the offense a federal one, which is subject to federal charges as well.

I, [Printed full name]__________________________
I understand the importance of not giving out medical information regarding any Client I currently assist, will assist in the future, or have assisted in the past. I have gone over the HIPAA law.

Signature____________________________ [date] ______________.

Care Planners INC.

HIPAA LAW DEFINITION

HIPAA stands for Health Insurance Portability and Accountability Act.

HIPAA is a law that went into effect August 21, 1996.

The law was developed to ensure people have privacy regarding their medical information.

No one working with an individual is allowed to share any medical information of that individual. This includes family members. If a signed release is obtained, you may be able to share information with only the people who the Client has requested have the information.

The specific information that is protected is information, including such data that relates to:

- **The individual's past, present, or future physical or mental health or condition.**
- **The provision of health care to the individual, or**
- **The past, present, or future payment for the provision of health care to the individual.**

Individually identifiable health information includes many common identifiers such as name, address, birth date, Social Security number.

____
Initials

YOUR RESPONSIBILITY AS A TEMPORARY EMPLOYEE

According to Minnesota State Statute, Section 268.095, subdivision 2, paragraph D an applicant who, within five calendar days after completion of a suitable temporary job assignment from a staffing employer: {1.} fails without good cause to affirmatively request an additional job assignment, or {2.} refuses without good cause an additional suitable job assignment offered, shall be considered to have quit employment. It is your responsibility to contact Care Planners Inc for additional assignments. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact Care Planners Inc once an assignment ends. I also acknowledge that I have received a copy of this form.

______________________________ ______/______/______

Employee signature **Date**

____

Employee {Please print your name}

______________________________ ______/______/______

Care Planners Inc Staff Signature **Date**

❖ **Tear off the bottom portion of this form for your records.**

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According to Minnesota State Statute, Section 268.095, subdivision 2, paragraph D an applicant who, within five calendar days after completion of a suitable temporary job assignment from a staffing employer: {1.} fails without good cause to affirmatively request an additional job assignment, or {2.} refuses without good cause an additional suitable job assignment offered, shall be considered to have quit employment. It is your responsibility to contact Care Planners Inc for additional assignments. If you fail to do so, it may affect your unemployment benefits.

OVERTIME WAGE AGREEMENT

It is agreed that Personal Care Assistant, ___________________________________, will wave past agreement to accept $____________. This will allow me to work for Care Planners Inc. only 40 hours per week. It is your responsibility to obtain approval before working any overtime hours. ***Overtime is not allowed without prior approval from Christopher Hanson***

_____________________________ _______________________

Personal Care Assistant **Date**

_______________________________ _______________________

Care Planners Inc, Administrator **Date**