CREATIVE HOME CARE
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New Hire Summary				
Name:				
Home Address				
Address 2nd Line				
Phone:				
Email:				
DOB:				
Social Security No.:				
Gender: Male/Female:				
Township:				
County:				
W-4 withholdings:				
Marital Status:				
Pay rate:				
2 Years Residency in PA?	Yes	◉	No	○
Has Driver's license?	Yes	◉	No	○
PA Driver's License #:				
Hire Date:				
Client Name:				
Potential Schedule:				
Work address:				

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EMPLOYEE NAME: _____ POSITION: _____

PHONE: _____ DATE OF HIRE: _____

Date of Application: 03/13/2020

PRE-HIRE CHECKLIST

☑	DL/State ID/ Green Card/Employment Card/SS Card/Citizenship/Passport
☑	Proof of Car Insurance ☐ Non-Driver
☑	PA Criminal Background Check (Online)
	Childline Clearance Required: ○ YES ◉ NO
	If Yes: ☐ FBI Child Abuse Clearance ☐ Online Child Abuse Clearance
	Have you been a PA resident for the last 2 years? ◉ YES ○ NO
	If Yes: ☑ Proof of 2 years' residence in PA
	If NO: ☐ FBI Fingerprint
☐	TB test: 2 step PPD or X-ray Results
☐	Direct Care Worker (DCW) Certificate
☐	HIPAA Test
☐	Staff Record of Training
☐	Documentation of Staff Competency
☐	Conditional offer of Job required: ○ YES ○ NO
☐	Math & English writing Test
☐	Company Health Insurance Accepted/Declined

Checked by: Yadu Niroula
(Authorized Creative HC Staff)

Revised by: _____
(Authorized Creative HC Staff/Supervisor)

PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION

Type or print clearly in ink. If obtaining this certification for non-volunteer purposes or if, as a volunteer having direct volunteer contact with children, you have obtained a certification free of charge within the previous 57 months, enclose an $13.00 money order or check payable to the PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES or a payment authorization code provided by your organization. **DO NOT send cash.**

Certifications for the purpose of "volunteer having direct volunteer contact with children" may be obtained free of charge once every 57 months.

Send to CHILDLINE AND ABUSE REGISTRY, PA DEPARTMENT OF HUMAN SERVICES, P.O. BOX 8170 HARRISBURG, PA 17105-8170.

APPLICATIONS THAT ARE INCOMPLETE, ILLEGIBLE OR RECEIVED WITHOUT THE CORRECT FEE WILL BE RETURNED UNPROCESSED. IF YOU HAVE QUESTIONS CALL 717-783-6211, OR (TOLL FREE) 1-877-371-5422.

PURPOSE OF CERTIFICATION (Check one box only)

- ☐ Foster parent
- ☐ Prospective adoptive parent
- ☐ Employee of child care services
- ☐ School employee governed by the Public School Code
- ☐ School employee not governed by the Public School Code
- ☐ Self-employed provider of child-care services in a family child-care home
- ☐ An individual 14 years of age or older applying for or holding a paid position as an employee with a program, activity, or service
- ☐ An individual seeking to provide child-care services under contract with a child care facility or program
- ☐ An individual 18 years or older who resides in the home of a foster parent for children for at least 30 days in a calendar year
- ☐ An individual 18 years or older who resides in the home of a certified or licensed child-care provider for at least 30 days in a calendar year
- ☐ An individual 18 years or older, excluding individuals receiving services, who resides in a family living home, community home for individuals with an intellectual disability, or host home for children for at least 30 days in a calendar year
- ☐ An individual 18 years or older who resides in the home of a prospective adoptive parent for at least 30 days in a calendar year
- ☐ Volunteer having direct volunteer contact with children

  If purpose is volunteer having direct volunteer contact with children, choose SUB PURPOSE:
  - ☐ Big Brother/Big Sister and/or affiliate
  - ☐ Domestic violence shelter and/or affiliate
  - ☐ Rape crisis center and/or affiliate
  - ☐ Other: _____
- ☐ PA Department of Human Services Employment & Training Program participant (signature required below)

SIGNATURE OF OIM/CAO REPRESENTATIVE _____ OIM/CAO PHONE NUMBER _____

AGENCY/ORGANIZATION NAME:	PAYMENT AUTHORIZATION CODE, IF APPLICABLE:

☐ Consent/Release of Information Authorization form is attached. Applicant must fill in the "Other Address" sections. By completing the other address sections, you are agreeing that the organization will have access to the status and outcome of your certification application.

APPLICANT DEMOGRAPHIC INFORMATION (DO NOT USE INITIALS)

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX
SOCIAL SECURITY NUMBER ___ ___	GENDER ☐ Male ☐ Female ☐ Not reported	DATE OF BIRTH (MM/DD/YYYY)	AGE

Disclosure of your Social Security number is voluntary. It is sought under 23 Pa.C.S. §§ 6336(a)(1) (relating to information in statewide database), 6344 (relating to employees having contact with children; adoptive and foster parents), 6344.1 (relating to information relating to certified or licensed child-care home residents), and 6344.2 (relating to volunteers having contact with children). The department will use your Social Security number to search the statewide database to determine whether you are listed as the perpetrator in an indicated or founded report of child abuse.

HOME ADDRESS	MAILING ADDRESS (if different from home address)	OTHER ADDRESS (if Consent/Release of Information Authorization form is attached)
ADDRESS LINE 1	ADDRESS LINE 1	ADDRESS LINE 1
ADDRESS LINE 2	ADDRESS LINE 2	ADDRESS LINE 2
CITY	CITY	CITY
COUNTY	COUNTY	COUNTY
STATE/REGION/PROVINCE	STATE/REGION/PROVINCE	STATE/REGION/PROVINCE
ZIP/POSTAL CODE	ZIP/POSTAL CODE	ZIP/POSTAL CODE
COUNTRY	COUNTRY	COUNTRY
☐ Different mailing address	ATTENTION	ATTENTION

CONTACT INFORMATION

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MOBILE TELEPHONE NUMBER
EMAIL (By submitting an email contact, you are agreeing to ChildLine contacting you at this address.)		

PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION

PREVIOUS NAMES USED SINCE 1975 (Include maiden name, nickname and aliases.)			
First	**Middle**	**Last**	**Suffix**
1.			
2.			
3.			
4.			
5.			

PREVIOUS ADDRESSES SINCE 1975 (Please list all addresses since 1975, partial address acceptable; attach additional pages if necessary.)
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

HOUSEHOLD MEMBERS
(Please list everyone who lived with you at any time since 1975 to present.
Please include parent, guardian or the person(s) who raised you; attach additional pages as necessary.)

Name (First, Middle, Last)	Relationship	Present Age	Gender
1.	☒ Parent ☐ Guardian ☐ person(s) who raised you		
2.	☒ Parent ☐ Guardian ☐ person(s) who raised you		
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

I affirm that the above information is accurate and complete to the best of my knowledge and belief and submitted as true and correct under penalty of law (Section 4904 of the Pennsylvania Crimes Code). If I selected volunteer, I understand that I can only use the certificate for volunteer purposes.

APPLICANT'S SIGNATURE

DATE

CHILDLINE USE ONLY		
DATE RECEIVED BY CHILDLINE	SUFFICIENT PAYMENT INFORMATION RECEIVED ☐ YES ☐ NO ☐ VALID PAYMENT AUTHORIZATION CODE ☐ WAIVED (supervisor initials) _____	CERTIFICATION ID #

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745 HARVEST DRIVE, HARRISBURG, PA 17111

Phone: 1-717-588-4300 FAX: 1-717-558-4344

EMAIL: INFO@CREATIVEHOMECARE.NET

HIPA Test

Employee Name: _____

Date Of Birth: _____

Date: _____

Signature: _____

Instructions: Please circle the correct letter for each question.

Question 1.	**A**	**B**	**C**	**D**	**E**
Question 2.	**A**	**B**	**C**	**D**	**E**
Question 3.	**A**	**B**	**C**	**D**	**E**
Question 4.	**A**	**B**	**C**	**D**	**E**
Question 5.	**A**	**B**	**C**	**D**	**E**
Question 6.	**A**	**B**	**C**	**D**	**E**
Question 7.	**A**	**B**	**C**	**D**	**E**
Question 8.	**A**	**B**	**C**	**D**	**E**
Question 9.	**A**	**B**	**C**	**D**	**E**
Question 10.	**A**	**B**	**C**	**D**	**E**

Score: ***%***

***To pass this test you would need to score at least 75%, (get at least 8 answers right out of 10 questions.)**

Employee Initial: _____

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STAFF RECORD OF TRAINING

Employee Name: _____

Employee Position: _____

Date of Training	Topic of Training	Name of Trainer / In-house	CPE hours	Certificate Yes/No	Remarks
	PA Pre-hire Competency Test				
	PA Direct Care worker (DCW) Initial Training On ADLs and IADLs				
	PA Direct Care Worker Training on Individual Service Plan (ISP/SAF)				
	Direct Care Worker (DCW) test				
	DCW Annual Training				

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Documentation of Staff Competency

Employee Name: _____

Creative Homecare's quality management procedure mandates that prior to commencing care, a staff person shall be trained on how to provide the service in accordance with the participant's service plan.

Documentation of Intake Competency and training to confirm staff credentials/qualifications to each PAS role on the participant's service plan: Circle:

a. Staff member attendance at onsite trainings on how to provide service in **Date:** _____ **Yes** **No**

b. accordance with participant's service plan. **Yes** **No**

c. Intake Competency Tests: **Yes** **No**

d. Direct Care Worker Certificate **Yes** **No**

e. Consumer Feedback **Positive** **Negative**

f. Certifications: RN, LPN, CAN, HHA, Other None

Creative Homecare has reviewed the individual's competency to perform assigned duties through: direct observation, testing, training, consumer feedback or other method approved by the Department or by a combination of methods.

Signed: _____ **Date** _____

Authorized Creative Homecare Representative

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SUPERVISION OF CONDITIONAL OFFERS

Applicant's Name: _____ Date: _____

Employee Position:

The above applicant has been given a conditional offer of employment pending the return of the background checks of ChildLine verification and termination procedures under the provisional hiring provision if the checks indicate a criminal history or a prohibited offense or occurrence.

Conditional job offers required: ○ Yes ◉ No

Date of Hiring: _____

Date of Background Check: _____

Creative Homecare shall monitor the provisionally hired applicant awaiting a criminal background check through random, direct observation and consumer feedbacks. The results of monitoring shall be documented in the applicant's file. An applicant will be terminated in writing immediately on receipt of the background check containing a prohibited offense.

Consumer contacts dates	**Performed by (Initials)**
_____	_____
_____	_____
_____	_____
Direct Observation dates	
_____	_____
_____	_____
_____	_____

Signed: _____
Authorized Creative Homecare Representative

CREATIVE HOMECARE, LLC	CREATIVE HOME CARE will exceed your expectations

Employee Name: _____

Date: _____ DOB: _____

Math and Writing Test

1. 10 + 15 +2 = _____

2. 11 – 3 = _____

3. 12 ÷ 4 = _____

4. 2 x 6 = _____

5. If you work six hours a day for seven days in a week, how many total hours would you put for a week in your timesheet?

_____

6. Please write a sentence with your name in it.

_____

_____
Creative Home Care Staff (Sign)

CREATIVE HOMECARE, LLC	

Employee Name: _____ Date: _____

HEALTH INSURANCE ACCEPTANCE/DECLINE

At the time of pre-hire paperwork, Creative Homecare (CHC) staff discussed with me regarding the health insurance (UPMC) provided by Creative Homecare to its eligible employees (those who work at least 32 hours of work per week). Considering the number of hours I work for this company, I am

- (●) Eligible for health insurance.
- ( ) Not eligible for health insurance.

My decision for the offer of health insurance by Creative Homecare is as follows:

- ( ) Accepted
- (●) Declined
- ( ) Not applicable due to ineligibility

_____ _____

Employee signature CHC Staff signature