



To apply for work as a
PCA, you will need all of
the following:

1. Current driver's license
2. Social Security Card
3. Current TB Skin test
4. Criminal Record Check with a seal
from your County Clerk of Court
5. Proof of Current Vehicle Insurance

Nurse Aid, LLC/Angel Hands Home Care

2722 NORTH CHURCH STREET ▲ SUITE E ▲ GREENSBORO, NC 27405 ▲ PHONE (336) 375-8288 FAX (336) 375-8926

E-mail: nurseaid98 @bellsouth.net

WELCOME

PCA

Dear Applicant,

I would like to take this opportunity to welcome you to Nurse Aid, LLC/Angel Hands Home Care. We hope your new job will live up to your expectations and your stay with us will be a rewarding one.

We are a small company that strives to work together as a team to achieve maximum results. This is necessary if we wish to sustain our growth and achievement in a highly competitive and changing industry. By working together, I am confident that the future will be both productive and prosperous for all of us.

In order to be considered for employment at Nurse Aid, LLC/Angel Hands Home Care, the state of North Carolina requires you to supply certain documentation at the time you apply. That documentation is listed below:

CNA's & PCA's

- Positive Photo Identification – We will make a copy. A copy brought in WILL NOT be accepted.
- Original Social Security Card - We will make a copy. A copy brought in WILL NOT be accepted.
- TB Skin test - We do administer TB shots at the Greensboro office by appointment. The cost for the shot is \$20.00 which must be paid for in cash prior to the shot being given. If you cannot take the TB shot and/or have tested positive in the past, you must provide a Chest X-Ray and you will be asked to complete a screening.
- INS Card – if you are not a legal permanent resident of the United States.
- CERTIFICATION - We will verify your certification status with DFS by your SSN. If you have any charges currently and/or pending against your certification, please let us know up front. It will show-up when we check your certification, and your honesty will play an important role in our decision whether to hire you or not, depending on the nature of the charges.
- Criminal Record Check – This report MUST come from the Clerk of Court from the county you reside in. If you have recently moved to a new county, it must come from the county in which you just moved from.

Other documentation may be required for certain facilities and/or special assignments. If you have any of the following items, please submit them, and we will place them in your personnel file.

- CPR Card
- Hepatitis B Vaccine Dates
- Med Tech Certification
- Health Immunization Record
- Medical Records Training

We will not process your application without the required documentation. We will only hold an incomplete file for 30 days from the date of the application. At that point, we will discard the file, and you would be required to reapply should you wish to.

Sincerely,

Donald H. Perkins

Donald H. Perkins
Administrator

Nurse Aid, LLC/Angel Hands Home Care

2722 N Church Street Suite E Greensboro, NC 27405
Phone (336) 375-8288 Fax (336) 375-8926

TERMS AND CONDITIONS OF EMPLOYMENT

I, the undersigned applicant, understand that Nurse Aid, LLC, dba Angel Hands Home Care, is a Part-Time PRN Staffing agency. As such, I understand that I am being employed as a “Part Time PRN” nursing assistant and I am not guaranteed 40 hours per week or any certain number of hours per week. I also understand that I am accepting the terms and conditions of this employment by my Signature/Seal below.

I further understand that my assigned client’s condition may deteriorate and that the client may be placed in a hospital or nursing facility for an extended period of time, or expire or have their service suspended for a period of time, so my continued employment is not guaranteed.

I understand that I am being employed to work part time and that the hours I accept for work may be controlled by the State of North Carolina through Administrative Policy and Procedure and North Carolina Medicaid Regulations. I agree to those terms and conditions.

I understand that it is my responsibility to check with the staffing coordinator on a daily basis for available fill-in cases or new permanent cases should any initial case be interrupted or end.

I also understand that I must have a working telephone number available to me and that I must return all calls made to that number asking me to call within a 6-hour time frame.

I also understand that it is a law and regulation in the State of North Carolina that I must maintain my medical records and that those medical records be updated as required and provided to the company. These Medical records include but are not limited to an annual TB Skin Test or a Chest X-Ray Screening conducted by a licensed health professional as outlined in General Statute 15A NCAC 19A. I further understand that my failure to provide proof of an annual test for tuberculosis will result in my not being eligible to work for Angel Hands Home Care or in a health care setting in the state.

Applicant Seal _____ Date _____

Witness Seal _____ Date _____

EMPLOYEE INFORMATION

THE INFORMATION ON THIS FORM WILL BE USED TO ENTER YOU, AS AN EMPLOYEE, INTO THE PAYROLL PROGRAM FOR THIS COMPANY. ALL INFORMATION ASKED IS NEEDED, AND IF THIS FORM IS INCOMPLETE, YOU WILL NOT BE PAID UNTIL YOU RETURN TO THE OFFICE TO COMPLETE IT.

NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHYSICAL STREET ADDRESS:(if different from above) (NO P.O. BOXES ALLOWED): _____

HOME PHONE:(_____) _____ E-MAIL ADDRESS: _____

WORK PHONE: (_____) _____ PAGER/CELL: (_____) _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ MARITAL STATUS: SINGLE: _____ MARRIED: _____

SEX: _____ ORIGIN/RACE: _____ DATE OF BIRTH: _____ / _____ / _____

CLASSIFICATION: PLEASE CHECK APPROPRIATE LEVEL(S) RN: _____ LPN: _____ CNA II: _____ CNA I: _____ COMPANION: _____ OTHER: _____

IN CASE OF EMERGENCY; PLEASE CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: (_____) _____

THIS INFORMATION WILL BE USED TO DETERMINE YOUR TAX WITHHOLDINGS EACH WEEK, SO IF YOU LEAVE IT BLANK, YOUR TAX DEDUCTIONS WILL BE BASED ON SINGLE WITH ZERO (0) DEPENDENTS.

TAX INFORMATION: PLEASE CHECK APPROPRIATE STATUS HOW MANY DEPENDANTS ARE YOU CLAIMING? ARE YOU FILING EXEMPT?

_____ SINGLE (49) W4: _____ YES _____
_____ MARRIED FILING SEPARATELY (79) NC4: _____ NO _____
_____ MARRIED FILING JOINTLY (79)
_____ HEAD OF HOUSEHOLD (78)

DO YOU WISH TO HAVE ANY ADDITIONAL WITHHOLDINGS? IF SO, PLEASE INDICATE: STATE: _____ FEDERAL: _____

EMPLOYEE SURVEY

I would prefer to be available for: Private Duty Cases Only _____ Staff Relief Only _____ Both Private Duty & Staff Relief _____

I would prefer to work the following shift(s): If more than one shift please list 1st, 2nd, 3rd choice.

7a-3p _____ 7a-7p _____ (if available)
 3p-11p _____ 7p-7a _____ (if available)
 11p-7a _____

I would prefer to work in the following area(s):

— Greensboro — Asheboro — Reidsville
— High Point — Burlington — Clemmons
— Winston-Salem — Thomasville — King
— Archdale/Trinity — Stokesdale — Other _____
— Kernersville — Eden _____
— Lexington — Madison/Mayodan _____

Please be aware that limiting your availability may limit your hours.

NURSE AID, LLC/ANGEL HANDS HOME CARE
AN EQUAL OPPORTUNITY EMPLOYER
APPLICATION FOR EMPLOYMENT

PERSONAL

DATE: ___/___/___

NAME: _____	D.O.B: _____/_____/_____
STREET ADDRESS: _____	SS #: _____
CITY: _____	STATE: _____ ZIP: _____
HOME PHONE: _____	PAGER/CELL: _____
ANY ADDITIONAL NUMBERS THAT MIGHT BE HELPFUL: _____	

TRAINING LEVEL - CLASSIFICATION: (PLEASE CHECK APPROPRIATE LEVEL)

REGISTERED NURSE _____	LICENSED PRACTICAL NURSE _____	CERTIFIED NURSING ASSISTANT II _____
CERTIFIED NURSING ASSISTANT I _____	OTHER: _____	SPECIFY _____
SPECIAL TRAINING: (CPR, ACLS, PALS, ETC) _____		

EDUCATION

HIGHEST GRADE ATTENDED _____	SCHOOL _____	YEAR FINISHED _____
COLLEGE ADDRESS _____	DEGREE/YEAR _____	
COLLEGE ADDRESS _____	DEGREE/YEAR _____	

EMPLOYMENT (START WITH MOST RECENT) BE SURE TO INCLUDE A PHONE NUMBER AND ACCURATE DATES.

FROM: _____	TO: _____	EMPLOYER: _____
JOB TITLE: _____	PHONE: _____	
SUPERVISOR'S NAME: _____	DUTIES: _____	
STARTING SALARY: _____	_____	
ENDING SALARY: _____	REASON FOR LEAVING: _____	
MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? YES _____ NO _____		
=====		
FROM: _____	TO: _____	EMPLOYER: _____
JOB TITLE: _____	PHONE: _____	
SUPERVISOR'S NAME: _____	DUTIES: _____	
STARTING SALARY: _____	_____	
ENDING SALARY: _____	REASON FOR LEAVING: _____	
MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? YES _____ NO _____		
=====		
FROM: _____	TO: _____	EMPLOYER: _____
JOB TITLE: _____	PHONE: _____	
SUPERVISOR'S NAME: _____	DUTIES: _____	
STARTING SALARY: _____	_____	
ENDING SALARY: _____	REASON FOR LEAVING: _____	
MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? YES _____ NO _____		

OTHER INFORMATION

SCHEDULE DESIRED: FULL TIME _____ PART TIME _____ TEMPORARY _____ PRN _____

RATE OF PAY DESIRED: _____ HOW DID YOU HEAR ABOUT OUR COMPANY? _____

HAVE YOU LIVED IN THE STATE OF NORTH CAROLINA FOR AT LEAST **5 CONSECUTIVE** YEARS? YES _____ NO _____

HAVE YOU EVER HAD ANY TYPE OF INJURY THAT WOULD PREVENT OR LIMIT YOUR ABILITY TO PERFORM THE DUTIES REQUIRED OF A MEDICAL PROFESSIONAL OF YOUR CLASSIFICATION? YES _____ NO _____

IF YES, WHEN? _____ WHAT WAS/IS THE INJURY? _____

DOES IT CURRENTLY AFFECT YOU? YES _____ NO _____ HOW? _____

HAVE YOU **EVER** FILED A WORKERS COMPENSATION CLAIM? YES _____ NO _____

HAVE YOU **EVER** BEEN CHARGED WITH / CONVICTED OF A FELONY? YES _____ NO _____ IF SO, WHEN? _____

HAVE YOU **EVER** BEEN ON PROBATION? YES _____ NO _____ IF SO, WHAT FOR? _____

ARE YOU **CURRENTLY** ON PROBATION? YES _____ NO _____ IF SO, WHAT FOR? _____

HAVE YOU WORKED **ANY AGENCY** BEFORE? YES _____ NO _____ REASON FOR LEAVING: _____

HAVE YOU **EVER** WORKED AT OR APPLIED TO **ANGEL HANDS HOME CARE OR NURSE AID, LLC**? YES _____ NO _____

IF SO, UNDER WHAT NAME? _____ REASON FOR LEAVING: _____

HOW DID YOU HEAR ABOUT OUR COMPANY/THE OPENING? _____

LIST ANY FRIENDS OR RELATIVES WORKING WITH US NOW: _____

PLEASE LIST ANY PETS/ANIMALS THAT YOU ARE AFRAID TO WORK AROUND. _____

PERSONAL REFERENCES (BE SURE TO INCLUDE PHONE NUMBER)

NOTE: Personal references should not include family members.

NAME	ADDRESS	RELATIONSHIP	PHONE
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

PROVIDE THE DATE YOU ARE AVAILABLE TO START: ____/____/____

WHAT DAYS AND SHIFTS ARE YOU AVAILABLE FOR WORK?

A patient’s care plan often calls for the caregiver to run errands with or for the patient one day per week. This would require the caregiver to have a valid driver’s license, valid insurance, as well as their own means of transportation.

Do YOU have a vehicle? _____ Do YOU have a VALID driver’s license? _____ DL#: _____

Do YOU have valid insurance on your vehicle? _____ Insurance Co. Name: _____

APPLICANT: READ AND SIGN BELOW

THE INFORMATION PROVIDED BY ME IN THIS APPLICATION FOR EMPLOYMENT IS **TRUE AND COMPLETE** TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF I AM EMPLOYED, **ANY FALSE STATEMENT WILL BE CONSIDERED AS CAUSE FOR POSSIBLE DISMISSAL**. FURTHERMORE, I HEREBY AUTHORIZE NURSE AID, LLC/ANGEL HANDS HOME CARE TO SEEK ANY INFORMATION NEEDED FROM ALL MY PREVIOUS EMPLOYERS, PERSONAL REFERENCES, AND/OR ACADEMIC INSTITUTIONS. I RELEASE ALL PARTIES FROM ANY LIABILITY THAT MAY ARISE FROM THEIR GIVING OR RECEIVING INFORMATION ABOUT ME AND MY SUITABILITY FOR EMPLOYMENT.

SIGNATURE OF APPLICANT (SEAL)

DATE

GUIDELINES AND JOB DESCRIPTION FOR SITTER/COMPANIONS

1. Sitters must be responsible, mature individuals, trained by their agency, capable of recognizing routine problems in patient comfort and safety and notifying the nurse.

SITTERS AND COMPANIONS DO NOT RENDER “HANDS ON” CARE!!!

2. Dress Code includes: tan uniforms, street hose, white shoes, and a Nurse Aid, LLC name tag which indicates classification.

3. Job Description includes:

- Inform the nurse of changes in the patient’s condition, patient needs and/or requests, or when assistance is needed. Change’s in the patients condition should never be called to the family or the physician by the sitter.
- Observe patient safety procedures (bed in low position, side rails up, restraints secure - do not adjust restraints in any way. Call the nurse if you observe the restraint to be too loose or too tight.
- Obtain instruction from nurse on what to watch for prior to beginning the shift.
- Maintain clean environment
- Provide care and arrangement of flowers

NURSE AID, LLC: If you do not go in uniform and wear your name tag, the Supervisor has the right to send you home without being paid for any time. Also, if you are working a shift, especially night shift, and go to sleep, the supervisor has the right to send you home and you will only be paid for the hours you were awake.

I have read and totally understand the above job description.

X _____
EMPLOYEE SIGNATURE

DATE

SITTER/COMPANION TEST

NAME: _____ (DARKEN IN THE BOX FOR THE ONE (1) BEST ANSWER)

1. The ultimate goal of nursing care is:
 complete recovery for every patient
 proper diagnosing and successful treatment of illness
 restoration of the patient to as near his/her former state of health as possible.
 all of the above
2. Illness or injury may affect an individual:
 emotionally
 physically
 financially
 spiritually
3. The person most qualified to met the spiritual needs of a patient is most likely to be:
 the nurse who has cared for him/her the longest
 the doctor who knows his family history
 any member of the patient's family
 the patient's minister or rabbi
4. Whenever a minister or rabbi visits a patient, the companion should:
 stay with the patient in case they are needed
 immediately notify the family
 be sure a written order from the doctor has been obtained before allowing the visit
 provide the patient and his spiritual advisor with privacy and interrupt only when necessary.
5. The ideal temperature for a sick room is considered to be:
 80 to 90 degrees F
 60 to 80 degrees F
 30 to 50 degrees F
 65 to 72 degrees F
6. Loud talking and laughing, slamming of doors, or dropping equipment must be avoided because:
 noise produces stimulation and fatigue
 they are usually against facility rules
 loud noises produce a gradual loss of hearing
 they may indicate a lack of interest in the patient
7. It is especially important that the sickroom be kept clean and orderly because:
 disorder creates mental confusion and affects the patient's peace of mind.
 cleanliness is more important than making the patient feel at home
 dirt and dust are carriers of disease
 most everyone needs practice in house-keeping methods
8. To remove dust from the furniture in a patient's room, it is best to use:
 An oily cloth
 A dry cloth
 A feather duster
 A damp cloth
9. The patient has received a bouquet of flowers and asks you to put them in a vase. You should:
 Dry the stems thoroughly and cut them straight across
 Place the flowers in warm water for a few minutes
 Place the stems in water and cut them diagonally
 Break stems off and place them in water
10. While putting your patients room in order you notice that he/she has a vase of wilted flowers on the table. He asks you not to disturb them. You should:
 Tell him the dead flowers are depressing and he/she would feel better if they were removed
 Ask him why he wants to keep dead flowers
 Put fresh water in the vase and leave them as requested
 Ask a family member to discard them during their next visit
11. When one is in a good sitting position the feet should be:
 Resting on the straight chair rung
 Kept at least twelve (12) inches apart
 Resting on the floor
 Dangling so that only the toes touch the floor
12. To avoid a serious accident when getting a patient up in a wheelchair, one must be sure that:
 The back of the chair is cushioned with a pillow
 The wheels are locked and the foot rests are folded up and out of the way
 A foot stool is used
 You have at least two (2) other people to help you

GRADE: _____

GRADED BY: _____

PCA SKILLS COMPETENCY CHECKLIST

Name: _____

Applicant: Please **circle** the appropriate skills level at which you are comfortable to perform these tasks.

(1) Need Instruction (2) Competent to perform

<u>PCA SKILLS</u>	<u>LEVEL</u>		<u>PCA SKILLS</u>	<u>LEVEL</u>	
CLEAN PATIENT ROOM	1	2	COMPLY WITH PATIENTS BILL OF RIGHTS	1	2
CLEAN BATHROOM	1	2	FOLLOWS CARE PLAN	1	2
CLEAN KITCHEN	1	2	DOCUMENTS APPROPRIATELY	1	2
LAUNDRY	1	2	COMMUNICATES WELL	1	2
CHANGE LINEN	1	2	PLAN & COORDINATE TRANSPORTATION NEEDS	1	2
PREPARE MEALS	1	2	KNOWLEDGE OF HOME & FIRE SAFETY	1	2
MAKE UNOCCUPIED BED	1	2	FOLLOW UNIVERSAL PRECAUTIONS	1	2
DOCUMENT ACCORDING TO POLICIES	1	2	DRESSING	1	2
SKIN CARE	1	2	GROOMING	1	2
<u>HOME CARE TASKS</u>	<u>LEVEL</u>		<u>HOME CARE TASKS</u>	<u>LEVEL</u>	
HOUSEKEEPING: <ul style="list-style-type: none"> ▪ Clean client's bedroom, kitchen, bathroom, and common living areas. ▪ Dust, Mop, Sweep, Vacuum 	1	2	MEALS: <ul style="list-style-type: none"> ▪ Preparation/Clean-up ▪ Set-up ▪ Feeding 	1	2
LAUNDRY: <ul style="list-style-type: none"> ▪ Make bed (unoccupied) ▪ Change bed linens ▪ Wash, dry, and fold linens, towels, etc. 	1	2	INFECTION CONTROL: <ul style="list-style-type: none"> ▪ Universal Precautions 	1	2
SAFETY: <ul style="list-style-type: none"> ▪ Fire Safety ▪ Falls Prevention ▪ Hazard Awareness ▪ Prevention of injury (skin tears, bruises, lacerations, bumps, etc.) 	1	2	COORDINATION OF CARE: <ul style="list-style-type: none"> ▪ Follow Plan of Care ▪ Communicate well ▪ Comply to Patients Bill of Rights ▪ Plan and coordinate patient transportation needs ▪ Document appropriately, completely, and accurately ▪ Report concerns immediately to supervisor 	1	2

I HEREBY VERIFY MY COMPETENCY TO PERFORM THE TASKS AND SKILLS AS INDICATED ABOVE.

Employee's Signature

_____/_____/_____
Date

Reviewer's Signature

_____/_____/_____
Date

Title: _____