



H o m e f o r A d u l t s

Pineview Commons

An Assisted Living Facility

INSTRUCTIONS FOR COMPLETING ATTACHED APPLICATION

Dear Applicant:

Thank you for your interest in employment at our community.

Attached you will find:

1. Employment Application – Complete first three (3) pages. Pages **MUST** be completed in full.
2. 2 Reference check forms. Please **ONLY** sign page two where indicated on both reference checks. **DO NOT COMPLETE REFERENCE FORMS.**

The attached application **MUST** be completed in full. Sign and date.

This application **CANNOT** be considered eligible for review unless completed in full.

Thank you

Management
Pineview Commons

Pineview Commons ACF/ALP LLC

Questionnaire for New Employees

Criminal History Record Check

Name: _____ Date Hired: _____

Maiden Name (if applicable): _____

Street Address: _____

City: _____ State: _____ Zip: _____

SS#: _____

Home Phone #: _____ Cell #: _____

Date of Birth: _____ County of Birth: _____

City of Birth: _____ Country of Birth: _____

Sex: _____ Race: _____

Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Mother's First Name: _____

Mother's Maiden Name: _____

NYS Department of Health, Criminal History Record Check Unit
chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

Last Name	First Name	Middle Initial	Maiden Name
Date of Birth (mm/dd/yyyy)	Alias/AKA	Mother's Maiden Name	
Mailing Address (street)	City	State	ZIP Code

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary. In accordance with applicable laws, DOH will furnish appropriate summary information to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for any non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.

NYS Division of Criminal Justice Services Criminal History Bureau Record Review Unit-5 th Floor 4 Tower Place Albany, NY 12203 (518) 485-7675	Federal Bureau of Investigation Criminal Justice Information Services (CJIS) Division 1000 Custer Hollow Road Clarksburg, WV 26306
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6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7. I certify to the best of my knowledge and belief that I (check as appropriate):
- ☐ Have ☐ Have not been convicted of a crime in New York State or any other jurisdiction
- ☐ Do ☐ Do not have a final finding of patient or resident abuse
- If you checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
8. My current mailing or home address is indicated in Section 1 of this form.
9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own.

Applicant Signature: _____	Date: ____/____/____
Name and Signature of Parent or Legal Guardian: _____ (if subject individual is under 18 years of age)	Date: ____/____/____

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: PINEVIEW COMMONS ACF/LLC	280-F-034
Agency Name: PINEVIEW COMMONS ALP/LLC	Operating License Number (PFI): 1288L001
Print Name of Authorized Person: KARA VOLLMER	Title: ADMINISTRATOR
Signature of Authorized Person: _____	Date: _____

Pineview Commons Assisted Living
201 South Melcher Street.
Johnstown, NY 12095
762-5488
Fax: 762-5583

REFERENCE CHECK

Name of Applicant: _____ Date: _____

Social Security#: _____

Name of Agency: _____

Employment Dates: _____ Job Title: _____

TO THE EMPLOYER:

The applicant listed above has applied for a position with Pineview Commons Licensed Home Care Services Agency, (LHCSA), Assisted Living Program, (ALP) and/or Adult Home ***and has listed you as a previous employer.*** We would appreciate your assistance in verifying this applicant's employment and in evaluating his/her job performance, so that we can maintain the highest caliber of health care personnel. All information will be held in the strictest confidence. Thank you for your cooperation.

1. Does the applicant history listed above correspond with your own records? Yes___ No___
If no, please give correct information: _____

2. Would you re-hire this employee? Yes___ No___
If no, please explain: _____

3. Has applicant had an In-service within the last two (2) months? Yes___ No___

4. What duties did the applicant perform? _____

5. Comments: _____

Name of Agency: _____

Employee Name: _____

PLEASE MARK AS: EXCELLENT GOOD AVERAGE POOR

Attendance	_____
Punctuality	_____
Dependability	_____
Quality of Work	_____
Job Knowledge	_____
Accepts Supervision	_____
Personal Appearance	_____
Attitude	_____

Name of Agency: _____

Name of Person Completing Form: _____

Title: _____ Date: _____

Applicant's Signature _____	Date _____
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Pineview Commons Assisted Living
201 South Melcher Street.
Johnstown, NY 12095
762-5488
Fax: 762-5583

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Attendance

Punctuality

Dependability

Quality of Work

Job Knowledge

Accepts Supervision

Personal Appearance

Attitude

Name of Agency: _____

Name of Person Completing Form: _____

Title: _____ Date: _____

Applicant's Signature

Date

PINEVIEW COMMONS HOME FOR ADULTS

**201 South Melcher Street
Johnstown, New York 12095
(518) 762-5488**

Last Name	First	Middle	Date
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Street Address	Home Phone	Business Phone
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City, State, Zip	Social Security #
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Position Desired	Circle One: Full-Time Part-Time	Pay Expected
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Other Special Training and Skills	Date You Can Begin Work
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Are you able to be flexible and report to work on short notice?	Yes___ No___
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Available Weekends and Holidays?	Yes___ No___
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Are you over eighteen years old?	Yes___ No___
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Are you able to rotate shifts if deemed necessary by the Home?	Yes___ No___
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Will you work overtime if asked?	Yes___ No___
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Will you take call and carry a beeper if needed or asked?	Yes___ No___
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SCHOOL	Name & Location of School	Course of Study	Years Completed	Diploma/ Degree
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College

High School

Elementary

Other

Do you have any physical, emotional, or mental disabilities that would prevent you from providing physical assistance and emotional support required of you to care for dependent adults? No___ If Yes___ Explain Fully: _____

Have you ever been convicted of a felony or a crime? No ___ If Yes ___ Explain Fully: ___

*****Please give accurate, complete full and part-time employment record. Start with present or most recent employer.**

EMPLOYMENT

1

Name of Employer Telephone

Address Employed (Month and Year)
From To

Name of Supervisor Weekly Pay

Job Title and Job Description Reason for Leaving

2

Name of Employer Telephone

Address Employed (Month and Year)
From To

Name of Supervisor Weekly Pay

Job Title and Job Description Reason for Leaving

3

Name of Employer Telephone

Address Employed (Month and Year)
From To

Name of Supervisor Weekly Pay

Job Title and Description Reason for Leaving

PERSONAL REFERENCES

Name	Telephone
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Address	Occupation
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Name	Telephone
------	-----------

Address	Occupation
---------	------------

Name	Telephone
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Address	Occupation
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Are you under the supervision of a caseworker, job coach, or any other agency that is assisting you in finding employment? Yes___ No___ If yes please explain:

What shift are you applying for: (check all that apply)

1st _____ (6:00 a.m. – 2:30 p.m.)
2nd _____ (2:15 p.m. – 11:00 p.m.)
3rd _____ (10:45 p.m. – 7:30 a.m.)

APPLICANT'S SIGNATURE

The information provided in this Application for Employment is true, correct, and complete. If employed, any misstatement or omission of fact on this application may result in my dismissal.

I understand that acceptance of an offer of employment does not create a contractual obligation upon the employer to continue to employ me in the future.

If you decide to engage an investigative consumer-reporting agency to report on my credit and personal history, I authorize you to do so. If a report is obtained, you must provide, at my request, the name and address of the agency so I may obtain the nature and substance of the information contained in the report.

I give you permission to check my references.

Signature of Applicant: _____ Date: _____

FOR EMPLOYER'S USE ONLY

<u>EMPLOYER</u>	<u>PERSONS CONTACTED</u>	<u>RESULTS</u>
-----------------	--------------------------	----------------

1. _____		
2. _____		
3. _____		

<u>PERSONAL</u>	<u>PERSONS CONTACTED</u>	<u>RESULTS</u>
-----------------	--------------------------	----------------

1. _____		
2. _____		
3. _____		

DATE: _____

INTERVIEWER'S NAME: _____ TITLE: _____

COMMENTS:

