SENIOR SOLUTIONS

Referral Application

Name:____Date:___________________

Address:____

City__________________________ State___________________ Zip______________

Home Phone: (______)______________________Cell Phone: (______)_____________________

E-Mail:___________________________________

SS#:________-______-___________ DOB_______/___________/___________

Emergency Contact Name:_______________________________Telephone:_____________________

Vehicle Information: Year:________Make:____________Model:____________Tag#________

1. Licenses/Certificates held: RN____ LPN _____ CNA ______HHA ______
2. License/Certificate #: (RN, LPN, CNA) _____________________ Exp. ________
3. Do you have any special training or skills? Hospice_______Alzheimer's________ Other:______
4. Have you ever been convicted of a crime?______________________________________
5. Have you registered with Senior Solutions registry in the past? ___________
6. Do you have any friends or relatives who work for or are in SSTC Registry? ______
7. If yes, who? ____
8. **Do you suffer from allergies?** (Pets, smoke, etc.)________________________________
9. Do you smoke? _____
10. How did you hear about Senior Solutions? _____________________________________

Educational Background

1. High School: ____Year Graduated___________
2. College:_______________________________Address:___________________________________
   a. Degree or Certificates earned:____
3. Trade/Vocation School:____
   a. Certificates earned:____

Employment History

Please list your work history, ***starting with the most recent***. **(Do not list relatives)**

1) Name of employer:__________________________________Supervisor:________________

   Address:____

   Phone: (   )__________________Fax: (   )____________________________

   Title:___________________________Reason for leaving:____________________________

   Dates employed:______________________________to______________________________

2) Name of employer:__________________________________Supervisor:________________

   Address:____

   Phone: (   )__________________Fax: (   )________________________________

   Title:___________________________Reason for leaving:____________________________

   Dates employed:______________________________to______________________________

3) Name of employer:__________________________________Supervisor:________________

   Address:____

   Phone: (   )__________________Fax: (   )____________________________

   Title:___________________________Reason for leaving:____________________________

   Dates employed:______________________________to______________________________

<u>Availability</u>

Please indicate HOURS you are available:
<u>Please fill in all blanks…</u>

<u>Private Duty</u>:

Monday	AM ☐____	PM ☐_____
Tuesday	AM ☐____	PM ☐_____
Wednesday	AM ☐____	PM ☐_____
Thursday	AM ☐____	PM ☐_____
Friday	AM ☐____	PM ☐_____
Saturday	AM ☐____	PM ☐_____
Sunday	AM ☐____	PM ☐_____

Would you be available for **1 or 2 hour bath visits**? ________

Name: ____________________________________Date:______________________

Circle preferences:

12 Hour Shifts:	Yes ☐	No ☐
Live – Ins:	Yes ☐	No ☐
Holidays:	Yes ☐	No ☐
Overnights:	Yes ☐	No ☐

<u>Comments regarding availability</u>:

____

____

____

Skills Evaluation

Name: ___________________________________Date:_____________________

Do you have any physical/mental disabilities that would limit your performance? ________

If so, explain: ____

____

How confident are you in each skill (answer with number that applies)

1= Extremely Confident 2= Very Confident 3= Confident 4 = Not Confident

You are able to lift:

______50 lbs.

______100 lbs.

______Use gait belt

Take vitals including:

______Pulse

______Temperatures: Rectal ______Oral ___

______Respiration

______Blood Pressures

______Changing patient position

______Oral Care/Dentures

______Transfer

______Operate Hoyer Lift

______Proper Body Mechanics

______Hair and Nail care

______Set up meals

______Do feedings

______Peg Tube feedings

______Dressing an incapacitated/semi-paralysis patient

______Walking assistance for semi-paralysis patient

______ Foley Cath/Ostomy Care

______ Measure inputs/outputs

______ Monitor tube feedings

______ Proper hand washing techniques

______ Range-of-motion exercises:

☐Upper ☐ Lower

______ Changing an occupied bed

______ Taking height/weight

______ Assess skin tears

______ Securing bedpan under Patient

______ Peri Care

______ Shower

______ Oxygen (Concentrator/Portable)

______ Hospice Experience

SENIOR SOLUTIONS

OF THE TREASURE COAST, INC.

PLEASE FAX TO: 772-334-0535

CONTRACTOR SECTION:

Name:____

I authorize Senior Solutions of the Treasure Coast, Inc., to obtain a reference check on me from the employer listed below:

_________________________________ _____________________

Signature Date

EMPLOYER/CONTRACTED AGENCY/REGISTRY:

The Independent Contractor has listed you on their Employment/Contract History. Please provide employment or contracted dates. Florida Law, Pursuant to Fla. Sat. 435.12(2)(b), requires a verification that the applicant has not had **a break in service**, in a position that requires a Level 2 screening, for more than ninety (90) days.

FIRST DATE OF SERVICE: _____/_____/___ LAST DATE OF SERVICE:___/_____/______

Position_____________________Would you rehire? Yes__________No__________

Comments:____

☐ Faxed Verification provided by:

Company Name:____

Employer/Contracted Representative's Name:_____________________________

Employer/Contracted Representative's Signature:__________________________

Title:______________________________Date:______________________________

PLEASE FAX COMPLETED FORM TO: LAURA A. YOUNG, ADMINISTRATOR

Office Use Only:

☐ **PHONE CALL ATTEMPT:**

1ST: Date:__________Time:_________VM____Busy_____**2ND** Date:__________Time:____VM____Busy____

☐ **FAX ATTEMPT:**

1st: Date:_________Time:_________**2nd** Date:_________Time:________

COMMENTS:

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The Independent Contractor's signature authorizes you to share any information regarding previous employment or contract.

FIRST DATE OF SERVICE: ______/______/____ LAST DATE OF SERVICE:____/_____/_______

Position________________________Would you rehire? Yes__________No__________

Comments:____

☐ Faxed Verification provided by:

Company Name:____

Employer/Contracted Representative's Name:_____________________________________

Employer/Contracted Representative's Signature:__________________________________

Title:________________________________Date:_______________________________

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1ST: Date:__________Time:_________VM_____Busy______**2ND** Date:__________Time:____VM_____Busy_____

☐ **FAX ATTEMPT:**

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COMMENTS:

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COMMENTS: