



WellCare

A Leader In Home Health Care

Well Care Home Health
2715 Ashton Drive
Suite 201
Wilmington, NC 28412
910.362.9405
888.815.5310
fax 910.790.3169

Well Care Home Care
2715 Ashton Drive
Suite 201
Wilmington, NC 28412
910.343-9996
800.868.9355
fax 910.343-0352

Well Care Home Care
101 East Satchwell Street
P.O. Box 279
Burgaw, NC 28425
910.259.6668
fax 910.259.6669

Well Care Home Care
118 Ocean Highway
P.O. Box 475
Supply, NC 28462
910.338-2763
fax 910.754.9702

Well Care Home Care
1349 South Madison St.
Whiteville, NC 28472
910.640.1150
fax 910.640.1162

Well Care Home Care
1104 W. Broad Street
Elizabethtown, NC 28337
910.862.6623
fax 910.872.0458

Well Care Home Care
1715-C Country Club Rd
Jacksonville, NC 28540
910.353.9788
fax 910.353.9895

Well Care Home Care
2501 Wayne Memorial Dr.
Suite B
Goldsboro, NC 27534
919-778-8212
Fax 919-778-8299



The Gold Seal of Approval™

Welcome to Well Care's employment application process. Enclosed is the application for employment and subsequent required forms. In order to process your application in a timely manner, we will need the following items returned as soon as possible:

- Valid Driver's License/ID Card
- Social Security Card or INS Card
- Copy of Auto Insurance card or policy with current dates of coverage
- Resume/Reference contacts with names, phone numbers and addresses

Any offer of employment is contingent upon consent for a criminal history record check in accordance with Regulation 131E-265. Well Care also conducts extensive reference checking, skills testing, motor vehicle record checks and any additional required investigations necessary when completing the application process.

Well Care will hire the most qualified applicants for positions and provide Equal Employment Opportunities for all applicants without regard to race, color, religion, sex, national origin, age, marital status or disability.

If you have questions, please do not hesitate to contact your local service center of the corporate Human Resource office. The corporate Human Resource office can be reached at 910-362-9405. Completed applications can be emailed to hr@wellcarehealth.com or faxed to 910-790-3169.

We look forward to talking with you soon!!

www.wellcarehealth.com

WELL CARE
APPLICATION FOR EMPLOYMENT

Position Applied for: RN LPN CNA CNAII Therapist PCA Administrative

Name: _____ SS#: _____ Date: _____

Telephone: Home _____ Cell Phone _____ Alternative _____

Email Address: _____

Current Mailing Address: _____

City: _____ State: _____ Zip: _____

How long have you lived at this address? ____ years ____ months

If you have lived at the current address less than 5 years, please list previous addresses:

Previous Address _____ How long? ____ years ____ months
City: _____ State: _____ Zip: _____ County: _____

Previous Address _____ How long? ____ years ____ months
City: _____ State: _____ Zip: _____ County: _____

How did you hear about Well Care? newspaper yellow pages job fair flyer letter in the mail
 friend (name _____) employee (name _____) other: _____

Are you presently employed? yes no May we contact your present employer? _____

Do you have a car available for work? yes no Bus route only? yes no
Driver's license number: _____ State: _____

Have you ever applied to work with Well Care before? yes no

Have you worked for Well Care before? yes no If so, When? _____

Do you have relatives previously or currently employed with Well Care? _____ If so, Who? _____

If hired, would you be able to show proof of authorization to work in the U.S.? _____

Date available to start: _____ Shift availability: 1st 2nd 3rd weekends holidays

Is your desire to work: Full-time (min. 32 hrs/week) part-time

If part time, please circle days available: M T W TH F SA SU

Salary range expected: _____

If hired, you may be required to work weekend and/or evening shifts.

Employment History

Start with current/most recent job first

| | | |
|---|-----------------------|--------------------|
| Start Date | Employer & Address: | Phone Number: |
| End Date | | |
| Starting Salary | Position held/duties: | Supervisor |
| Ending Salary | | Reason for leaving |
| <input type="checkbox"/> full time <input type="checkbox"/> part time | | |
| Start Date | Employer & Address: | Phone Number: |
| End Date | | |
| Starting Salary | Position held/duties: | Supervisor |
| Ending Salary | | Reason for leaving |
| <input type="checkbox"/> full time <input type="checkbox"/> part time | | |
| Start Date | Employer & Address: | Phone Number: |
| End Date | | |
| Starting Salary | Position held/duties: | Supervisor |
| Ending Salary | | Reason for leaving |
| <input type="checkbox"/> full time <input type="checkbox"/> part time | | |

Education

| Education | School Name & Location | Attended | | Years Completed | Degree |
|---------------------|------------------------|----------|----|-----------------|--------|
| | | From | To | | |
| High School | | | | | |
| Vocational Training | | | | | |
| Community College | | | | | |
| University | | | | | |
| Post-Graduate | | | | | |

References

List three (3) persons who are familiar with your qualification and are not related to you. Please provide complete name, phone numbers and association. This page must be completed to be considered for employment.

1. Name _____ Phone: (H) _____ (W) _____
Type of Association: _____
2. Name _____ Phone: (H) _____ (W) _____
Type of Association: _____
3. Name _____ Phone: (H) _____ (W) _____
Type of Association: _____

Current Professional License/Certification

RN LPN CNA CNAII SLP PT PTA OT OTA Other: _____

License/Certification # _____ State _____ Expiration _____

Has your professional license/certification ever been under investigation and/or revoked? _____ If yes, please explain: _____

Background Information

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Have you ever been suspended, dismissed, fired or discharged from a position of employment? |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Has your driver's license ever been suspended? |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Have you ever plead guilty or been convicted of ANY violation of the law other than a minor traffic violation? |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Have you ever plead guilty or been convicted of a felony, been imprisoned, placed on probation or paroled? |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Are you now under any restriction for violation of law for which you pled guilty or were convicted? |

If you answered "yes" to any of these questions, please attach a separate page explaining your response. Please provide details regarding times and dates of the occurrences; reason for discharge; names/numbers/addresses of employers; and names/numbers/addresses of police or criminal agencies involved.

Certification and Authorization

I certify that the answers given herein are true and complete to the best of my knowledge. I understand that false or misleading information given in my application or interview(s) may result in rejection of my application or termination if employed by Well Care Health Services, Well Care Home Health, or Well Care LLC. I understand that I am required to comply with the rules and regulations of Well Care at all times.

Well Care may ask any questions which they consider relevant to their hiring decision, including questions about my personal background, education background, work experience, character, personality and personal responsibility and waive access to this information.

I agree to submit to a physical examination (if required) and to random drug testing. I authorize anyone to give Well Care civil or criminal history concerning me.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

Applicants Signature: _____

Date: _____ Social Security Number: _____



WellCare

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Do not write below this line.

WELL CARE

**DISCLOSURE & RELEASE FORM
EMPLOYEE DRIVING RECORD INFORMATION**

1. In connection with my employment (or my application for employment), I hereby give permission to Well Care., (hereinafter referred to as Employer) to obtain my state driving record (also known as my motor vehicle record or MVR).
2. I acknowledge and understand that my driving record is a consumer report that contains public record information.
3. I authorize, without reservation, any party or agency contacted by Employer, to furnish the above-mentioned information.
4. I understand that I have the right to request a copy of my driving record and to know the source or sources of my driving record, for a two-year period preceding my request.
5. This authorization shall remain on file by Employer for the duration of my employment, and will serve as ongoing authorization for Employer to procure my state driving record at any time during my employment period.
6. I understand that Employer may take adverse action affecting my employment, based on information in my driving record. If such adverse action is taken, I acknowledge that my rights are as follows:
 - Employer must notify me in writing of any such adverse action.
 - I have the right to receive a copy of the driving record upon which the adverse action was based.
 - I have the right to receive a summary of my rights under the Fair Credit Reporting Act. I have the right to know the name, address and phone number of the consumer reporting agency that provided my driving record to Employer.
 - I have the right to obtain a free copy of my driving record from the agency that provided it, if such request is made within 60 days from the date that Employer took adverse action.
 - I have the right to dispute the accuracy or completeness of my driving record with the consumer reporting agency that provided it, and request that errors be corrected.

Employee's Name (Print)

Employee's Signature

Date Signed

Social Security Number

Driver's License Number & State

Date of Birth

NOTIFICATION AND RELEASE

Sales Representative Matt Montgomery

Company Name Well Care Home Health

Access ID _____ BeeCheck ID 0000122546637800 CAC Code WE45

The information contained in my application for employment with (company name) Well Care Home Health (hereinafter, "The Company") is true to the best of my knowledge and belief. I understand that any misrepresentation or false statement made by me in connection with the application or any related documents which is deemed material by The Company shall result in The Company not employing me or, if employed, terminating my employment. I understand and agree that all information furnished in my application and all attachments may be verified by The Company or its authorized representative. I hereby authorize all individuals and organizations named or referred to in my application and any law enforcement organization to give The Company all information relative to such verification and hereby release such individuals, organizations and The Company from any and all liability for any claim or damage resulting therefrom. I hereby acknowledge that I have been informed by The Company that The Company may seek to obtain a consumer report and/or investigative report that will include personal information regarding me, including but not limited to, educational history, work references, driving record, drug testing and criminal convictions or arrest records if allowed, in order to assist The Company in making certain employment decisions. I further acknowledge notification by The Company that reports may be provided to The Company by other firms subcontracted for that purpose. I, my heirs, assigns and legal representatives, hereby release and fully discharge The Company, its parent and affiliated companies and the respective officers, directors, shareholders, employees, agents of each, including subcontractors, from any and all claims, monetary or otherwise, that I may have against The Company, its parent, affiliates or subcontractors, arising out of the making, or use of, either a consumer report and/or investigative report, including any errors or omissions contained or omitted from such reports or investigations. The Company agrees to inform you if an employment decision has been influenced by information contained in a consumer report, made at our request by Castle Branch Inc. You may obtain a free copy of the report within sixty days by calling Castle Branch Inc. collect at (910) 815-3880 or toll free at (888) 520-0520. The Company will make available to you "A Summary of Your Rights Under The Fair Credit Reporting Act."

PLEASE PRINT

Name (First, Middle, Last) _____ Date of Birth (mo/day/yr) _____ / _____ / _____
Maiden Name or "AKA" (First, Middle, Last) _____ Dates Used (yr) from _____ to _____
Social Security # _____ - _____ - _____ Driver's License # _____ State _____

Current and previous address(es). PROVIDE ALL ADDRESSES FOR PREVIOUS 7 YEARS. (Use extra page if necessary)

Street _____ From _____
City, State, Zip, County _____ To _____
Street _____ From _____
City, State, Zip, County _____ To _____
Street _____ From _____
City, State, Zip, County _____ To _____

Applicant Signature _____ Date _____
signature required

| For Employer Use Only: Please mark (✓) the searches to be conducted. | | | |
|--|--|--------------------------|-------|
| Contact <u>Rema James</u> | Email <u>rjames@wellcarehealth.com</u> | | |
| Phone <u>910-362-9405</u> | Fax <u>910-790-3169</u> | | |
| <input type="checkbox"/> WellCare Standard Package | <input type="checkbox"/> | <input type="checkbox"/> | Notes |
| ST-Criminal | | | |
| Residencv Historv | | | |
| ST-Motor Vehicle | | | |