



## **Cornerstone Home Care**

8800 Glacier Hwy., Suite 111

Juneau, AK 99801

907-586-6838

1-877-956-CARE (2273)

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### **Position Applying for: Direct Service Provider**

**Please submit only complete applications to be considered for hire. Complete applications include:**

- **Fully filled out application with signature and date**
- **3 completed Work Reference forms**
- **Complete availability form**

**After hire, we will require the following credentials within 10 days of hire:**

- **Current auto insurance (if driving)**
- **Current ID or Driver's License**
- **You will also be required to participate in a CPR/First Aid course with Cornerstone Home Care or furnish copies of current certification if you have already completed training within the last 2 years.**

**Contact us with any questions regarding this application**  
**907-586-6838 or 1-877-956-2273**



CORNERSTONE HOME CARE  
 8800 Glacier Hwy Suite 111 Juneau, AK 99801  
 907-586-6838 or 1-877-956-2273

POSITION APPLYING FOR: \_\_\_\_\_

YOUR NAME: \_\_\_\_\_  
                     Last  First  Middle

ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_

ARE YOU LEGALLY ELIGIBLE FOR EMPLOYMENT IN THE U.S.A.?  Yes  No (If yes, verification will be required.)

TELEPHONE: \_\_\_\_\_  
 \_\_\_\_\_

ARE YOU ABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF THE POSITION WITH OR WITHOUT ACCOMMODATIONS?  Yes  No

EMAIL: \_\_\_\_\_

HAVE YOU EVER BEEN "CHARGED or CONVICTED" OF A MISDEMEANOR OR FELONY?  Yes  No  
 HAVE YOU EVER BEEN CONVICTED OF ANY CRIME RELATED TO SEXUAL MISCONDUCT or CHILD ABUSE?  Yes  No

If yes, please elaborate: \_\_\_\_\_

Education	Yrs. Completed	Field of Study	Graduate or Degree
High School			
College/University			
Business/Technical			
Other (May include grammar school)			

MILITARY SERVICE:  Yes  No

Duty/Specialized Training: \_\_\_\_\_

In case of accident or illness please contact: Name: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

**EMPLOYMENT:** List most recent employment first. Include summer or temporary jobs. Be sure all your experience or employers related to this job are listed here, in the summary (following this section), or use an extra sheet of paper if necessary.

Employer Name and Address	Position Title/Duties Skills	Dates Employed	
		From	To
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	Supervisor's Name: _____ Telephone: _____	_____	Reason for leaving

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Summarize other employment related to this job: \_\_\_\_\_

Proficient with computers or other office Equipment?  Yes  No  
 SPECIFY: Types of computers, other electronic or mechanical equipment that you are qualified to operate or repair: \_\_\_\_\_

Professional Licenses, Certifications or Registrations: \_\_\_\_\_

Do you have a CPR / First Aid Certificate  Yes  No

Additional skills including supervision skills, other languages, or information regarding the career/occupation you wish to bring to the employer's attention: \_\_\_\_\_

Information to the applicant: As part of our procedure for processing your employment application, your personal and employment references may be checked. If you have misrepresented or omitted any facts on this application, and are subsequently hired, you may be discharged from your job. You may make a written request for information derived from the checking of your references.  
 If necessary, for and during employment, you may be required to: supply your birth certificate or other proof of authorization to work in the US, have a physical examination and/or a drug test, or to sign a conflict of interest agreement and abide by its terms.

**Employment at Cornerstone Home Care is on an "at-will" basis and is for no definite period and may regardless of the date or method of payment of wages or salary, be terminated at any time with or without cause. Other than the Board of Directors of Cornerstone Home Care, no supervisor, manager or other person, irrespective of title or position, has authority to alter the at-will status of your employment or to enter into any employment contract for a definite period of time with you. Any agreement with you altering your at-will employment status must be in writing and signed by the Board of Directors.**

I understand and agree to the information shown above:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Equal Employment Opportunity: While many employers are required by federal law to have an Affirmative Action Program, all employers are required to provide equal employment opportunity and may ask your national origin, race and sex for planning and reporting purposes only. This information is optional and failure to provide it will have no affect on your application for employment.

Employer Section: \_\_\_\_\_



# CORNERSTONE HOME CARE

8800 Glacier Hwy., Suite 111 Juneau, AK 99801 Phone: (907) 586-6838 Fax: (907) 586-8114

## New Employee Reference Form (3 work references required) TOP PORTION TO BE FILLED OUT BY APPLICANT

Applicant Name: \_\_\_\_\_

Position Applied for: \_\_\_\_\_

Work Reference Name: \_\_\_\_\_  
*(Reference cannot be a relative or current staff of Cornerstone Home Care.)*

How do you know this person? \_\_\_\_\_

Phone Number: \_\_\_\_\_ Best days/time to contact you if needed: \_\_\_\_\_

## BOTTOM PORTION TO BE COMPLETED BY AGENCY

How long have you worked with or known the applicant? \_\_\_\_\_  
*(Must be at least 3 years)*

	Excellent	Good	Satisfactory	Poor	Unacceptable
Dependability/ Meets deadlines					
Works cooperatively with others					
Appearance					
Follows instructions					
Problem- solving ability					
Sets priorities appropriately					
Learns new skills					
Punctuality					
Treats coworkers/clients					
Communicates effectively in Speech					
Communicates effectively in Writing					

Would you re- hire this person? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, why not? \_\_\_\_\_

Thank you for your time and consideration, we may call you to verify the information that you have provided. Please feel free to call us with any questions as well.

Reference Signature \_\_\_\_\_ Date \_\_\_\_\_



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Reference Signature \_\_\_\_\_ Date \_\_\_\_\_



Department of Health and Social Services

DIVISION OF HEALTH CARE SERVICES Background Check Program

4601 Business Park Blvd., Bldg K Anchorage, Alaska 99503-7167 Main: 907.334.4475 Fax: 907.269.3488

Alaska Background Check Application

\*Asterisks mark required fields. Applications will not be processed without complete information.

Personal Information

Full Legal Name: Last First M.I. Date of Birth (mm/dd/yyyy)

Permanent/ Physical Address: Physical Street Address Apartment/Unit # City State ZIP Code

Mailing Address (if different than Permanent/ Physical Address): Mailing Address Apartment/Unit # City State ZIP Code

Primary Phone: ( ) Secondary Phone: ( )

\*Applicant's Email Address:

\*SSN (or ITN): This is an ITN

Demographic Information

\*Race: (Asian, Black, White, Native American, or Unknown) \*Gender: (Male, Female, Unknown, Other) \*Eye Color: (Black, Blue, Brown, Hazel, Green, Grey, Unknown) \*Hair Color: (Black Blonde, Brown, Grey, Sandy or Light Brown, Red, White, Unknown) \*Height: FT IN \*Weight: Lbs. \*Place of Birth (Country/State): US Citizen(Y/N):

Alias

Aliases/Prior Names (includes all names by which a person is currently known as, or has previously gone by, including nick names): Please attach additional pages as necessary

First Name: Middle Name: Last Name: SSN/ITN: Date of Birth: (mm/dd/yyyy) This is an ITN

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**Prior Address History**

**Prior Addresses in the last 10 years:** Please list the state(s) in which you have lived outside of Alaska for the last 10 years. This includes those states in which you have lived for schooling or training even if you remained an Alaska resident during that time. If you have lived in Alaska for the entirety of the last 10 years, you do not need to complete this section. Please attach additional pages as needed.

State: \_\_\_\_\_ Year(s) From: \_\_\_\_\_ to \_\_\_\_\_  
State: \_\_\_\_\_ Year(s) From: \_\_\_\_\_ to \_\_\_\_\_  
State: \_\_\_\_\_ Year(s) From: \_\_\_\_\_ to \_\_\_\_\_

**Pre-Employment Information**

**Pre-Employment Information:** Only complete this information if you are applying directly with a licensed and/or certified entity. The entity should provide you this information. If the entity does not provide this information to you, leave this section blank.

Provider Name: Cornerstone Home Care  
State Program under which the individual will work, such as Assisted Living, PCA, Hospital, Hospice, etc.: PCA  
Position Title: Personal Care Worker  
Position Type: Employee  
(Employee/Independent Contractor/Volunteer/Other)

**Instructions**

- 1. You should only submit this form to the Background Check Program (BCP) if you have not already applied on-line or through a licensed and/or certified entity. You may apply on line at: <https://nabcs.dhss.ak.local/bcpapplicant>. Hard copy applications will only be processed in the order in which they are received and will not be processed until a full and complete application is received, including all applicable fees and fingerprint cards.
- 2. Hard copy applications submitted to the BCP will not be connected to any other application or to any specific provider type within the system and require fingerprint cards and all applicable fees. **Please note fees are non-refundable.**
- 3. Hard copy applications submitted to the BCP must be complete within 30 days from the date the application was received. All fees and fingerprint cards must be **received by** the BCP within the 30 day timeframe. Applications found incomplete after 30 days are automatically closed. If you still require a background check, you will be required to submit a new application including all fees and fingerprints.
- 4. Payments may be made by check, credit card or money order. Cash payments may only be made in person at 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503. All payments must be for the exact amount. If you wish to pay by credit card, you must contact the Background Check Program at (907) 334-4475 to make a payment over the phone. Fees for fingerprint based background checks are \$76.50 and are **not refundable.**
- 5. Please ensure you provide a valid email address. The email address will be used to communicate with you regarding your application status, including information regarding determinations or needed information.
- 6. If an eligible determination is made, you must associate with a licensed and/or certified entity within 100 days of the determination. Unassociated applications will be closed after 100 days without further notice and will immediately render a background check invalid. If you continue to need a valid criminal history check, you will be required to submit a new application including all fees and fingerprints.
- 7. A complete application includes this application form, non-refundable payment in the amount of \$76.50, and one set of fingerprints. Complete applications should be mailed to: State of Alaska, Background Check Program, 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503.

I, \_\_\_\_\_, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization for Background Check will be held in confidence in accordance with DHSS guidelines.

I, \_\_\_\_\_, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

Applicant Signature

Date





## RELEASE OF INFORMATION AUTHORIZATION FOR BACKGROUND CHECK

\*\*\*This form must be signed by the applicant for a background check and must be maintained in the individual's personnel file. If requested by the department, the form must be provided within 24 hours.\*\*\*

I, \_\_\_\_\_, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization for Background Check will be held in confidence in accordance with DHSS guidelines.

I, \_\_\_\_\_, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

I, \_\_\_\_\_, understand that upon submission of my fingerprints will be used to check the criminal history records of Alaska and of the Federal Bureau of Investigations (FBI).

I, \_\_\_\_\_, understand that procedures for obtaining a change, correction, or updating of an FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.

\*\*\*This form must be signed; if the individual is 16-17 years of age, a parent signature must also be included.\*\*\*

\_\_\_\_\_  
Printed Name of Applicant (must be legible)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Applicant's SSN

\_\_\_\_\_  
Parent Printed Name, if applicable (must be legible)

\_\_\_\_\_  
Parent Signature.



# CORNERSTONE HOME CARE

8800 Glacier Hwy., Suite 111 Juneau, AK 99801  
Phone: (907) 586-6838 Fax: (907) 586-8114

## Payroll Deduction Agreement

I, \_\_\_\_\_ (employee name) authorize my employer,

Cornerstone Home Care, to deduct \$88.25 from my paycheck to reimburse the agency for the cost of my fingerprint background check required by the State.

This deduction will occur over:

### CHECK ONLY ONE

The next pay period for the total amount of \$88.25.

OR

The next two pay periods in the amount of \$44.12 and \$44.13 per pay period.

I understand that if my employment ends before the total amount is paid in full, the remaining amount will be taken out of my last paycheck.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

For Office Use Only:

Information sent to Payroll

Initials:

Please fill out all areas of form.

### STAFF AVAILABILITY

Please highlight the times you are available, and cross out the times you are not available.

NAME:					MODE OF TRANSPORTATION:		
IN WHAT LOCATION DO YOU LIVE?							
	SUN	MON	TUES	WED	THU	FRI	SAT
6AM							
7AM							
8AM							
9AM							
10AM							
11AM							
12PM							
1PM							
2PM							
3PM							
4PM							
5PM							
6PM							
7PM							
8PM							
9PM							
10PM							
11PM							
MIDNIGHT							

<input type="checkbox"/>	YES, I AM AVAILABLE AND WILLING TO WORK OVERNIGHT IF NEEDED.
<input type="checkbox"/>	NO, I AM UNABLE TO WORK OVERNIGHT.