

Standard Application for Employment

It is our policy to comply with all applicable state and federal laws prohibiting discrimination in employment based on race, age, color, sex, religion, national origin, disability or other protected classifications.

Please carefully read and answer all questions. You will not be considered for employment if you fail to completely answer all the questions on this application. You may attach a résumé, but all questions must be answered.

"Employer" Judah Med Care LLC	Position applying for PCA/BHA/CNA/RN/LPN
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PERSONAL DATA			
Name (last, first, middle)			
Street Address and/or Mailing Address		City	State
Home Telephone Number	Business Telephone Number	Cellular Telephone Number	
Date you can start work	Salary Desired	Do you have a High School Diploma or GED? Yes <input type="checkbox"/> No <input type="checkbox"/>	

POSITION INFORMATION Check all that you are willing to work			
Hours: Full Time <input type="checkbox"/>	Days <input type="checkbox"/>	Swing <input type="checkbox"/>	Status: Regular <input type="checkbox"/>
Part Time <input type="checkbox"/>	Evenings <input type="checkbox"/>	Graveyard <input type="checkbox"/>	Temporary <input type="checkbox"/>
		Weekends <input type="checkbox"/>	
Are you authorized to work in the U.S. on an unrestricted basis?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever been convicted of a felony? (Convictions will not necessarily disqualify an applicant for employment.)		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, explain:			
Have you been told the essential functions of the job or have you been viewed a copy of the job description listing the essential functions of the job? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Can you perform these essential functions of the job with or without reasonable accommodation? Yes <input type="checkbox"/> No <input type="checkbox"/>			

QUALIFICATIONS Please list any education or training you feel relates to the position applied for that would help you perform the work, such as schools, colleges, degrees, vocational or technical programs, and military training.			
	School Name	Degree	Address/City/State
School			
School			
Other			

SPECIAL SKILLS List any special skills or experience that you feel would help you in the position that you are applying for (leadership, organizations/teams, etc.)			
SS#			
Email address			

REFERENCES Please list three professional references not related to you, with full name, address, phone number, and relationship. If you don't have three professional references, then list personal, unrelated references.			
Name	Address/City/State	Phone	Relationship

WORK HISTORY Start with your present or most recent employment and work back. Use separate sheet if necessary. (INCLUDE PAID AND UNPAID POSITIONS)

Job Title #1	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

May we contact your present employer? Yes No N/A

Job Title #2	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

Job Title #3	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

Job Title #4	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

I certify that the facts set forth in this Application for Employment are true and complete to the best of my knowledge. I understand that if I am employed, false statements, omissions or misrepresentations may result in my dismissal. I authorize the Employer to make an investigation of any of the facts set forth in this application and release the Employer from any liability. The employer may contact any listed references on this application.

I acknowledge and understand that the company is an "at will" employer. Therefore, any employee (regular, temporary, or other type of category employee) may resign at any time, just as the employer may terminate the employment relationship with any employee at any time, with or without cause, with or without notice to the other party.

Applicant Signature

Date

(JMC) Judah Med Care, LLC Acknowledgment statement

I acknowledge that I have read and understand the employees policies and procedures. I will follow policy as an employee of JMC. I am giving JMC permission to use my personal information for employment purposes only.

Signature

Date

JMC Diagnostic Screening Acknowledgement Form

Please be advised every employee is required to have a 10 Panel drug screen, Background Check, and Tuberculosis Test/ PPD in order to work for any state facilities and Homecare to be in compliance. If you don't have your own provider the agency of Judah Med Care has possible participating providers to offer you to conduct all testings, but fees are due at the time of service.

Name

Date

Please note:

Judah Med Care and Participating Providers all accept Cashapp and US Dollars

TB/ PPD Test: \$35.00 (for each testing step administered)

Sled Background Test: \$26.00

Drug Screening Test: \$25.00

If you have any questions or concerns about the costs of test please feel free to contact the agency at:

Judah Med Care

803-233-7554

and/ or

803-667-2936

HOME HEALTH AIDE SKILLS CHECKLIST

Directions: Please carefully assess your strengths and select the appropriate experience level for each skill. This information will be utilized by ProStat, Inc. and may be shared with our clients.					1 = Proficient (Expert) 2 = Experienced (Performs Independently) 3 = Familiar (May require assistance) 4 = Unfamiliar (No Experience)				
Vital Signs					Safe Transfer Techniques				
	1	2	3	4		1	2	3	4
Temperature - Oral					Range of Motion ROM				
Temperature - Rectal					Repositioning in Bed				
Temperature - Axillary					Walker				
Pulse - Radial					Hoyer Lift				
Pulse - Apical					Assist with Ambulation				
Blood Pressure					Housekeeping Duties				
Containing Respirations					Washing Clothes				
Personal Care ADL					Folding Clothes				
Bed Bath					Dishes				
Sponge Bath					Mop Floors				
Tub Bath					Dusting				
Shower					Grocery Shopping / Errands				
Nail and Skin Care					Meal Preparation				
Hair Care					Assist with Feeding				
Oral Hygiene					Diabetic Diet				
Brush					Low Sodium Diet				
Swab					Special Diet Instructions				
Denture Care					Care Experience				
Shave - Razor					Care of Alzheimer Client				
Shave - Electric					Care of Client with Respiratory Difficulties				
Assist with Dressing					Care of Client with Stroke				
Elimination					Care of Client with Head Injury				
Use of Bed Pan					Diabetic Care				
Bowel Program					Care of the Amputee Client				
Use of Bedside Commode					Care of Bed Bound Client				
Measure Urine Output					Care of the Paraplegic or Quadriplegic Client				
Empty Foley Catheter Drainage Bag					Client Transportation				
Nursing Notes Charting / Documentation					Assist in and out of vehicle				
Home Health Aide Plan of Care					Use of Manual Wheelchair				
Home Health Aide Flow Sheet					Use of Electric Wheelchair				
Skin Assessment									

I attest that the above checklist evaluating my experience and competency was completed truthfully to the best of my knowledge.

Printed Name _____ Date _____ Signature _____ Date _____

HOME HEALTH CARE

Aide Skills Inventory

Date: _____ Caregiver Name: _____ CNA _____ HHA _____

Please mark an X in the appropriate box next to each entry based on your experiences in patient care.

Skill	Experienced	Needs Review	Not Capable	Skill	Experienced	Needs Review	Not Capable
SPECIALTY CARE				PERSONAL CARE			
Infant 0-2 yr				Tub Bath/Shower			
Pediatric 2-13 yr				Bed Bath/Sponge Bath			
Adolescent 13-18 yr				Hair Care			
Adult				Oral/Mouth Care			
Geriatric				Denture Care			
Alzheimer's/Dementia				Hearing Aids			
Parkinson's Disease				Skin Care/Grooming			
Hospice Care				Shaving			
Spinal Cord Injury				Nail Care			
Brain/Head Injury				Foot Care			
Stroke				Pressure Sore Precautions			
Amputee				NUTRITION			
Diabetes				Prepare/Serve Meals			
Cardiac/Heart				Fluid Restrictions			
Pulmonary/Respiratory				Assist with Feeding			
HOUSEWORK				Intake/Output Readings			
Laundry/Washer/Dryer				PEG Site Care			
Dishes/Dishwasher				Swallow Precautions			
Linens/Making Beds				UNIVERSAL PRECAUTIONS			
Vacuum/Mop				Use of Protective Equipment			
Garbage Disposal				Masks			
Blender				Gloves			
TRANSFERRING				Gowns/Aprons			
Wheelchair				CPR Shields			
Pivot				VITAL SIGNS			
Repositioning				Temperature			
Hoyer				Pulse			
Slide Board				Respirations			
DRESSING				Blood Pressure			
Upper Body				TOILETING			
Lower Body				Toilet Transfers			
Sock Aids				Use of Bedside Commode			
Shoe Horn				Use of Bedpan/Urinal			
Immobilizers				Foley Cath Care			
TED Hose/Elastic Stockings				Empty Ostomy			
Orthopedic Devices				Use of Diapers/Depends			
Prosthesis				AMBULATION			
OTHER				Use of Gait Belt			
Medication Reminders				Range of Motion			
Weight/Scale				Weight-bearing Restrictions			
Languages Spoken				Ambulation with Devices			
Languages Read/Write				(Cane, Walker, Crutches)			

06071M

South Carolina COVID 19 Vaccine Religious Exemption Form

I, _____ Personally appeared before a public notary and swear or affirm as follows:

1. I am an employee of _____ located at _____.
My employer has recommended that employees be vaccinated.
2. I understand that the DHEC Department Of Public Health has determined that COVID-19 vaccinations are necessary to prevent the spread of dangerous diseases among the people of this state.
3. I understand that my exemption notwithstanding, I may be subject to other accommodations during the pandemic.

By _____ Date _____



JUDAH MED CARE, LLC
IN HOME CARE AGENCY

EMPLOYEE EMERGENCY CONTACT FORM

Name _____

Work Place _____ Work Telephone # _____

Employee Contact Info

Home Address _____

City, State, Zip _____

Primary Contact # _____ Secondary Contact # _____

Email Address _____

Emergency Contact Info

Name _____ Relationship _____

Primary Contact # _____ Secondary Contact # _____

Name _____ Relationship _____

Primary Contact # _____ Secondary Contact # _____

This document will be used in any event of a emergency

Enforceable non-compete disclosure

No employee or subcontractor of Judah Med Care LLC under any circumstances whatsoever is permitted to work for any facility and or client that Judah Med Care LLC is contracted with outside of working hours through the agency. In the event that the employee or subcontractor of Judah Med Care LLC is no longer working for the agency, they are not permitted to work for the facility or the client they were sent to by Judah Med Care LLC for least twelve months past their departure date, Unless they are properly bought out by the company or the client. Legal ramifications requested of violating this non-compete agreement will include but is not limited to a Lawsuit for punitive damages for malicious conduct, liquidated damages, actual losses, or injunction. If it is found that a former employee or subcontractor of Judah Med Care LLC is indeed working for a facility or client that the agency sent them to after receiving this non-compete, they will have the same legal ramifications filed against them. This form is to be signed and sent back to Judah Med Care LLC within 48 hours of receiving it or current employees or subcontractors will immediately be removed from the schedule. Applicants will not be considered if they do not sign.

Enforced by: Lateya Smith
Owner/ admin



Personal Item Policy

1. Judah Med Care LLC is not in any way responsible for the loss of personal Items at any facility or clients homes. It is solely your responsibility to keep up with your belongings.
2. We ask that you not bring any valuables such as jewelry, or High end brand Items to your place of employment.
3. If for any reason you have your cell phone handy we ask that you keep your location on just in case it should need to be found.
4. Lastly it is imperative that your children, any other family members, or friends are not brought to work. It is unacceptable to have visitors while you're working due to HIPPA standards and regulations.

Thank you for your services. Judah Med Care LLC truly appreciates everything you do

Signature:

Lateya Smith
Judah Med Care (Owner)
803-233-7554
Katwana Samuels
Manager
803-238-9721
Stephanie Miles
Homecare Supervisor
706-341-8236
Judah Med Care Opt
803-667-2936

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

Individual/sole proprietor or single-member LLC

C Corporation

S Corporation

Partnership

Trust/estate

Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

Other (see instructions) ▶ _____

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

6 City, state, and ZIP code

7 List account number(s) here (optional)

Requester's name and address (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number									
				-			-		
or									
Employer identification number									
				-					

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here

Signature of U.S. person ▶

Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
 - Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
 - Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
 - Form 1099-S (proceeds from real estate transactions)
 - Form 1099-K (merchant card and third party network transactions)
 - Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
 - Form 1099-C (canceled debt)
 - Form 1099-A (acquisition or abandonment of secured property)
- Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.