



**BRILLIANT QUALITY NURSING LLC – HOME CARE AGENCY**

**Licensed Homemaker Companion Agency – HCA.0002757**

**1429 Pembroke St Apt 1A, Bridgeport, CT 06608**

**Phone: 475-375-4799      Email: brilliantqualitynursingschool@gmail.com**

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## **1 CAREGIVER APPLICATION FORM**

**TITLE: CAREGIVER EMPLOYMENT APPLICATION**

**Position Applying For:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Full Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Address:** \_\_\_\_\_

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**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Are you authorized to work in the U.S.?**

Yes     No

**Do you have reliable transportation?**

Yes     No

**Position(s) interested in (check all that apply):**

Companion     Homemaker     PCA  
 HHA     CNA     Live-in

**Certifications (attach copies if available):**

CNA License # \_\_\_\_\_ State: \_\_\_\_\_

HHA Certificate     PCA Certificate     CPR Card

**Years of caregiving experience:**

0–1     1–3     3–5     5+

**Previous Employer 1:** \_\_\_\_\_

**Duties:** \_\_\_\_\_

**Dates:** \_\_\_\_\_ **Phone:** \_\_\_\_\_



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**Previous Employer 2:** \_\_\_\_\_

Duties: \_\_\_\_\_

Dates: \_\_\_\_\_ Phone: \_\_\_\_\_

**Skills (check all that apply):**

- Bathing       Dressing       Toileting
- Transfers       Hoyer Lift       Dementia Care
- Meal Prep       Light Housekeeping
- Medication Reminders       Companionship
- Vital Signs       Hospice/End-of-Life Support

**Emergency Contact Name:** \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**APPLICANT CERTIFICATION**

I certify that the information provided is true and complete.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **2 BACKGROUND CHECK AUTHORIZATION FORM**

**TITLE:** CRIMINAL BACKGROUND CHECK AUTHORIZATION

**Full Name:** \_\_\_\_\_

**Other Names Used (if any):** \_\_\_\_\_

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Address:** \_\_\_\_\_

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**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

I authorize **Brilliant Quality Nursing LLC – Home Care Agency** to obtain criminal background information about me, including:

- State and/or national criminal history
- Sex offender registry status
- Public court records

This information will be used for employment and placement decisions.

I understand that false information may result in denial or termination of employment.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **3** HIPAA CONFIDENTIALITY AGREEMENT

**TITLE:** HIPAA PRIVACY & CONFIDENTIALITY AGREEMENT

**Employee Name:** \_\_\_\_\_

I understand that, as a caregiver, I may have access to confidential client information, including health, personal, and financial details. I agree that:

- I will not discuss client information with anyone who is not authorized.
- I will not share client information on social media or with friends/family.
- I will keep all paper and electronic information secure.
- I understand that violating confidentiality may result in termination.

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **4** EMPLOYEE FILE CHECKLIST

**TITLE: EMPLOYEE FILE DOCUMENT CHECKLIST**  
(Agency Use Only)

**Employee Name:** \_\_\_\_\_

**Start Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- Employment Application
- Copy of Photo ID
- Social Security Card (if applicable)
- Background Check Completed
- Judicial Search Completed
- TB Test / Immunization Record
- CNA / HHA / PCA Certificate (if applicable)
- CPR Card
- Direct Deposit Form
- Emergency Contact Form
- Signed HIPAA Agreement
- Signed Policies & Procedures Acknowledgment
- Caregiver Service Agreement

**Reviewed By (Admin):** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **5 DIRECT DEPOSIT AUTHORIZATION FORM**

**TITLE:** DIRECT DEPOSIT AUTHORIZATION

**Employee Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Bank Name:** \_\_\_\_\_

**Routing Number:** \_\_\_\_\_

**Account Number:** \_\_\_\_\_

Account Type:

Checking     Savings

I authorize **Brilliant Quality Nursing LLC** to deposit my wages directly to the account listed above. This authorization remains in effect until I submit written notice.

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **6 EMERGENCY CONTACT FORM**

**TITLE: EMERGENCY CONTACT INFORMATION**

**Employee Name:** \_\_\_\_\_

**Primary Contact Name:** \_\_\_\_\_

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

Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

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

**Secondary Contact Name (optional):** \_\_\_\_\_

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

Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **7 CAREGIVER JOB DESCRIPTION**

**TITLE:** CAREGIVER / PCA / HOMEMAKER JOB DESCRIPTION

**Position:**  Companion  Homemaker  PCA  HHA  CNA

**Summary of Duties:**

Caregiver provides non-medical support services to clients in their homes, including:

- Companionship and supervision
- Assistance with ADLs (if permitted)
- Light housekeeping and laundry
- Meal preparation and feeding assistance
- Medication reminders (no administration of injections)
- Safety monitoring and reporting changes in condition

**Essential Functions (check to acknowledge):**

- Able to lift and assist clients safely
- Able to perform light housekeeping
- Able to communicate clearly in English
- Able to follow care plans and instructions

**Employee Acknowledgment:**

I have read and understand the duties of this position.

**Employee Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**8) CAREGIVER SERVICE AGREEMENT**

**TITLE:** CAREGIVER EMPLOYMENT SERVICE AGREEMENT

This agreement is between **Brilliant Quality Nursing LLC – Home Care Agency** and:

**Employee Name:** \_\_\_\_\_

**1. Position & Classification**

Employee is hired as:  Companion  Homemaker  PCA  HHA  CNA

**2. Work Expectations**

Employee agrees to:

- Arrive on time for all shifts
- Call agency in advance if unable to work
- Follow each client's care plan
- Maintain professionalism and respect

**3. Pay & Scheduling**

Pay rate and schedule will be communicated separately in writing.

**4. Confidentiality & Conduct**

Employee agrees to follow:

- HIPAA rules
- Agency Code of Conduct
- Zero-tolerance policy for abuse/neglect

**5. Termination**

Employment may be ended for:

- Repeated lateness or no-calls
- Violation of policies
- Unsafe behavior or abuse

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Administrator Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **9) POLICIES & PROCEDURES ACKNOWLEDGMENT**

**TITLE: POLICIES & PROCEDURES ACKNOWLEDGMENT FORM**

I, \_\_\_\_\_, acknowledge that I have received and reviewed the **Brilliant Quality Nursing LLC Policies & Procedures**, including but not limited to:

- Code of Conduct
- Attendance and Call-Out Policy
- Dress Code
- Client Rights and Safety
- Abuse/Neglect Reporting
- HIPAA & Confidentiality

I understand that I am responsible for following these policies at all times.

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **10 TB / IMMUNIZATION CLEARANCE FORM**

**TITLE:** TB TEST / IMMUNIZATION CLEARANCE FORM

**Employee Name:** \_\_\_\_\_

TB Test Completed    Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Result:  Negative     Positive

Chest X-Ray (if needed)    Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Immunization Record Provided  
(Check all that apply if known):  
 MMR     Varicella     Tdap     Hep B

**Clinic / Provider Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## **11** **SUBSTITUTE W-9 INFORMATION FORM**

*(Not the official IRS W-9 – internal use only)*

**TITLE:** SUBSTITUTE TAXPAYER INFORMATION FORM (INTERNAL USE)

**Name (as on tax records):** \_\_\_\_\_

**Business Name (if any):** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

- Individual / Sole Proprietor
- Single-Member LLC
- Corporation
- Other: \_\_\_\_\_

**Tax ID (SSN or EIN):** \_\_\_\_\_

I certify that the number shown above is my correct taxpayer identification number and that I am not subject to backup withholding under IRS rules.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_



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## **12 INCIDENT REPORT FORM**

**TITLE: INCIDENT / OCCURRENCE REPORT**

**Employee Name (reporting):** \_\_\_\_\_

**Date of Incident:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Time:** \_\_\_\_\_

**Client (Initials only):** \_\_\_\_\_

**Type of Incident (check all that apply):**

- Fall     Injury     Medication Issue  
 Abuse/Neglect Concern     Behavior Change  
 Other: \_\_\_\_\_

**Location of Incident:** \_\_\_\_\_

**Description of Incident:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Action Taken:**

\_\_\_\_\_  
\_\_\_\_\_

**Was 911 called?**  Yes  No

**Was Family Notified?**  Yes  No

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Administrator Review:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_