

**We consider applicants for all positions without regard to race, color, religion, sex, national origin, age, marital status, the presence of a non-job-related medical condition or handicap, or any other legally protected status.**

**PLEASE PRINT**

<b>Position(s) Applied For:</b>				<b>Date of Application:</b>	
<b>How Did You Learn About Us?</b>	<input type="checkbox"/> Advertisement	<input type="checkbox"/> Friend	<input type="checkbox"/> Walk-In	<input type="checkbox"/> Employment Agency	
	<input type="checkbox"/> Relative	<input type="checkbox"/> Other:			

<b>Last Name:</b>		<b>First Name:</b>		<b>Middle Name:</b>	
<b>Address:</b>		<b>City:</b>		<b>State:</b>	
				<b>Zip Code:</b>	
<b>Telephone Number(s):</b>					

**If you are under 18 years of age, can you provide required proof of your eligibility to work? .....**  Yes  No

**Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status?**

Yes  No

*(Proof of citizenship or immigration status will be required upon employment.)*

**Have you been convicted of a felony within the last 7 years? .....**  Yes  No

*If Yes, please explain:*

**Do you know of any reason why you cannot perform the essential functions of the job for which you are applying with or without reasonable accommodation? .....**  Yes  No

**Have you been employed under any other names? .....**  Yes  No

*If Yes, list name(s):*

**Have you ever been employed with us before? .....**  Yes  No

*If Yes, give date:*

**State names of relatives and friends working for us, other than your spouse.**

**Can you travel if a job requires it? .....**  Yes  No

**On what date would you be available for work? .....**

**Have you ever had any job-related training in the United States**

**Military? .....**  Yes  No

*If Yes, please describe:*

# Education

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School	Name and Location of School	Course of Study	Years in Attendance From - To	Did you Graduate?	Degree or Diploma

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**List any foreign languages you can speak, read, and/or write.**

Speak	Read	Write

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**List professional, trade, business, or civic activities and offices held.**

*You may exclude memberships which would reveal sex, race, religion, national origin, age, ancestry, handicap, or other protected status:*

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## Special Skills and Qualifications

*Summarize special job-related skills and qualifications acquired from employment or other experience.*

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## References

*Give name, address, and telephone number of three references who are not related to you and are not previous employers.*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

# Employment Experience

Start With Your Present or Last Job

<b>Employer:</b>		<b>Dates Employed</b>		<b>Work Performed</b>
		<b>From</b>	<b>To</b>	
<b>Address:</b>				
<b>Telephone Number(s):</b>		<b>Hourly Rate/Salary</b>		
<b>Job Title:</b>	<b>Supervisor:</b>	<b>Starting</b>	<b>Final</b>	
<b>Reason for Leaving:</b>				
<b>Employer:</b>		<b>Dates Employed</b>		<b>Work Performed</b>
		<b>From</b>	<b>To</b>	
<b>Address:</b>				
<b>Telephone Number(s):</b>		<b>Hourly Rate/Salary</b>		
<b>Job Title:</b>	<b>Supervisor:</b>	<b>Starting</b>	<b>Final</b>	
<b>Reason for Leaving:</b>				
<b>Employer:</b>		<b>Dates Employed</b>		<b>Work Performed</b>
		<b>From</b>	<b>To</b>	
<b>Address:</b>				
<b>Telephone Number(s):</b>		<b>Hourly Rate/Salary</b>		
<b>Job Title:</b>	<b>Supervisor:</b>	<b>Starting</b>	<b>Final</b>	
<b>Reason for Leaving:</b>				
<b>Employer:</b>		<b>Dates Employed</b>		<b>Work Performed</b>
		<b>From</b>	<b>To</b>	
<b>Address:</b>				
<b>Telephone Number(s):</b>		<b>Hourly Rate/Salary</b>		
<b>Job Title:</b>	<b>Supervisor:</b>	<b>Starting</b>	<b>Final</b>	
<b>Reason for Leaving:</b>				

## Applicant's Statement

I certify that answers given herein are true and complete to the best of my knowledge.

I authorize investigation of all statements in this application for employment as may be necessary in arriving at an employment decision, including criminal history checks as required by law.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time. I hereby understand and acknowledge that, unless otherwise defined by applicable law, any

employment with this organization is of an 'at will' nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this 'at will' employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, that I am required to abide by all rules and regulations of the Employer.

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

\_\_\_\_\_  
Date



At Home

## Qualification Assessment and Pre-screening Tool

Care Manager applicant: Please complete these questions in order to help us assess your qualifications for the role of a Humana At Home Network Field Care Manager.

Instructions on how to properly save this assessment:

*In order for us to read your complete responses, please "Save As" this document. This will allow the form to remain an expandable.*

Applicant's name:

Date:

1. Describe your care management experience in a community based or in-home setting:

2. Describe your most professionally challenging case/patient, how did you work with the case/patient?

3. How would you engage a member to accept Humana At Home services?

4. What would you teach a member with CHF or Diabetes about the disease process, and how might you help them manage their care?

5. What is the greatest number (caseload) of patients you have managed in the past?

## At Home

6. What is the greatest number of weekly home visits you have managed in the past?

7. How comfortable are you working independently from your home and contacting your supervisor and other support via phone/email?

8. What is your comfort level working with computer based systems?

## Care Manager Info Sheet

### Practice Information

Practice Name <i>Giving Tree Senior Care Options, LLC</i>		
Follow Up Contact Name <b>Monica Grumme and Mary Angelique Knoblock</b>	Follow Up Contact Phone Number <b>228-467-5900</b>	Follow Up Contact Email <a href="mailto:mgrumme@givingtreems.com">mgrumme@givingtreems.com</a> and <a href="mailto:mary@givingtreems.com">mary@givingtreems.com</a>

### Care Manager Information

Name		
Address		
City	State	Zip Code
Business Telephone <b>228-467-5900</b>	Cell	Fax <b>228-467-5777</b>
Address to send ID badges <i>If same as above, write "same"</i> 4313 Leisure Time Drive Diamondhead, MS 39525		
Date of Birth	Email	Phone Number
Status Full-time <input checked="" type="checkbox"/> Part-time	If part-time, indicate the days and hours the Care Manager is available: <b>Monday thru Friday and occasional Saturdays</b> <b>8 a.m. – 5 p.m.</b>	
Geographical Areas Covered		

### Care Management Specialty Areas

Please indicate any Care Management specializations

- |                                                                            |                                                |                                     |                                                 |                                          |
|----------------------------------------------------------------------------|------------------------------------------------|-------------------------------------|-------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Developmental Disabilities                        | <input type="checkbox"/> Entitlements/Benefits | <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Medical                | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Sign Language/Hearing or vision impaired patients | <input type="checkbox"/> Mental Health         | <input type="checkbox"/> Rehab      | <input type="checkbox"/> Environment and Safety | <input type="checkbox"/> Dementia        |



At Home<sup>SM</sup>

**Licenses and Certifications**

License Type	State	License #	Exp. Date
License Type	State	License #	Exp. Date
License Type	State	License #	Exp. Date
Certification Type	Date Received	Exp. Date	Issuing Organization
Certification Type	Date Received	Exp. Date	Issuing Organization
Certification Type	Date Received	Exp. Date	Issuing Organization

I certify that all of the representations made above are accurate and truthful. I represent that in working with Humana At Home Care Management Network, my company, employees, subcontractors and I agree to abide by the Code of Ethics of our parent profession(s). I affirm that I agree to work in a collaborative team with the other professionals and Humana At Home staff.

Signature	Date