WE CARE RECOVERY

Behavioral Health Residential Facility • 9129 S 48th Dr, Laveen, Arizona

CAREGIVER APPLICATION PACKET

APPLICATION PACKET CONTENTS

GENERAL CAREGIVER INFORMATION

PERSONAL INFORMATION

Full Legal Name (First, Middle, Last):

Preferred Name (if different):

Date of Birth: Social Security Number:

Email Address:

Phone (Primary): Phone (Secondary/Alternate):

ADDRESS INFORMATION

Current Street Address:

City: State: ZIP Code:

How long at current address?:

If less than 2 years at current address, provide previous address:

Previous Street Address:

City: State: ZIP Code:

POSITION INFORMATION

Position Applied For: Caregiver

Desired Start Date:

Availability: ☐ Full-Time ☐ Part-Time ☐ PRN / As Needed

Preferred Shift: ☐ Day ☐ Evening ☐ Overnight ☐ Weekends ☐ Flexible

Expected/Desired Hourly Rate (optional):

CAREGIVER EXPERIENCE & SKILLS

Total years of caregiving experience:

Have you worked with any of the following populations? (Check all that apply)

- ☐ Adults with serious mental illness (SMI)
- ☐ Adults in substance use recovery
- ☐ Adults with developmental or intellectual disabilities
- ☐ Elderly / geriatric residents
- ☐ Adults with traumatic brain injury (TBI)
- ☐ Adults with co-occurring disorders
- ☐ Other:

Languages spoken (other than English):

Have you completed any of the following trainings? (Check all that apply)

- ☐ De-escalation / crisis intervention
- ☐ Trauma-informed care
- ☐ Medication assistance / administration
- ☐ HIPAA / patient privacy training
- ☐ Mandated reporter training
- ☐ CPI / Handle With Care / MANDT or similar

ADDITIONAL INFORMATION

Are you 18 years of age or older? ☐ Yes ☐ No

Are you legally authorized to work in the United States? ☐ Yes ☐ No

Have you ever been employed by We Care Recovery before? ☐ Yes ☐ No

If yes, dates of employment: _____ Position held: _____

Do you have any family members or close personal relationships with current residents, employees, or contractors of We Care Recovery? ☐ Yes ☐ No

If yes, please describe: _____

How did you hear about this position?: _____

EDUCATION HISTORY

List highest level of education completed and any post-secondary or specialized training.

HIGH SCHOOL / GED

School Name: _____

City, State: _____ Year Completed: _____

Diploma/GED Received? ☐ Yes ☐ No

COLLEGE / VOCATIONAL / TECHNICAL

Institution Name: _____

City, State: _____ Dates Attended: _____

Major / Program of Study: _____ Degree/Cert.: _____

Did you graduate? ☐ Yes ☐ No ☐ In Progress

ADDITIONAL EDUCATION OR SPECIALIZED TRAINING

Institution / Program: _____

City, State: _____ Dates: _____

Subject / Certification: _____ Completed? _____

BEHAVIORAL HEALTH / CAREGIVING TRAINING

List any behavioral health, mental health, recovery, or direct care training programs:

Program 1: _____

Program 2: _____

Program 3: _____

I certify that the educational information above is true and complete. I authorize We Care Recovery to verify any of the institutions, dates, and degrees listed.

SIGN

Applicant Signature: _____ Date: _____

Print Name: _____

EMPLOYMENT HISTORY

Please list your most recent employers, starting with the current or most recent. Include all positions held within the last 10 years. Attach additional sheets if necessary. Please explain any gaps of 30 days or more.

EMPLOYER 1

Company/Employer Name: _____

Address (City, State): Phone:
Supervisor Name: Job Title/Position:
Employment Dates — From: To:
Starting Pay Rate: Ending Pay Rate:
Reason for Leaving:
May we contact this employer? ☐ Yes ☐ No
Brief description of duties/responsibilities:

EMPLOYER 2

Company/Employer Name:
Address (City, State): Phone:
Supervisor Name: Job Title/Position:
Employment Dates — From: To:
Starting Pay Rate: Ending Pay Rate:
Reason for Leaving:
May we contact this employer? ☐ Yes ☐ No
Brief description of duties/responsibilities:

EMPLOYMENT HISTORY (continued)

EMPLOYER 3

Company/Employer Name:
Address (City, State): Phone:
Supervisor Name: Job Title/Position:
Employment Dates — From: To:
Starting Pay Rate: Ending Pay Rate:
Reason for Leaving:
May we contact this employer? ☐ Yes ☐ No
Brief description of duties/responsibilities:

EMPLOYER 4

Company/Employer Name:
Address (City, State): Phone:
Supervisor Name: Job Title/Position:
Employment Dates — From: To:
Starting Pay Rate: Ending Pay Rate:
Reason for Leaving:
May we contact this employer? ☐ Yes ☐ No

Brief description of duties/responsibilities:

EMPLOYMENT GAPS

Please explain any gaps in employment of 30 days or more within the last 10 years:

I certify that the information provided in this employment history is true and complete to the best of my knowledge. I authorize We Care Recovery BHRF to verify the above information with any past employer listed.

Applicant Signature: _____ Date:

Print Name:

PROFESSIONAL REFERENCES

Please provide three (3) professional references who can speak to your work ethic, character, and ability to perform caregiver duties. References must NOT be family members. At least two (2) must be former supervisors or coworkers.

REFERENCE 1

Full Name: Relationship:

Job Title: Company/Organization:

Phone Number: Email:

How long have you known this person? In what capacity?

REFERENCE 2

Full Name: Relationship:

Job Title: Company/Organization:

Phone Number: Email:

How long have you known this person? In what capacity?

REFERENCE 3

Full Name: Relationship:

Job Title: Company/Organization:

Phone Number: Email:

How long have you known this person? In what capacity?

AUTHORIZATION TO CONTACT REFERENCES

I authorize We Care Recovery to contact each of the references listed above and to ask any questions related to my work history, character, judgment, and suitability for the position of Caregiver. I release each reference and We Care Recovery from any liability arising from this inquiry or the information provided.

Applicant Signature: _____ Date:

Print Name:

CRIMINAL HISTORY DISCLOSURE

Conviction of a crime is not an automatic bar to employment. Each conviction will be evaluated on a case-by-case basis in accordance with Arizona law and the requirements of A.R.S. § 36-411 and the Arizona Fingerprint Clearance Card statutes. Failure to disclose is grounds for denial of employment or immediate termination.

1. Have you ever been convicted of a felony? ☐ Yes ☐ No
2. Have you ever been convicted of a misdemeanor (other than minor traffic)? ☐ Yes ☐ No
3. Are you currently on probation, parole, or community supervision? ☐ Yes ☐ No
4. Do you have any pending criminal charges? ☐ Yes ☐ No
5. Have you ever been required to register as a sex offender? ☐ Yes ☐ No
6. Have you ever had a Fingerprint Clearance Card application denied, suspended, or revoked? ☐ Yes ☐ No

If you answered YES to any of the above, please explain (offense, date, jurisdiction, disposition):

I certify that the responses above are true and complete. I understand that any false statement or omission may result in denial of employment or immediate termination, regardless of when discovered.

SIGN

Applicant Signature: _____ Date:

Print Name:

DRIVER'S LICENSE & MOTOR VEHICLE RECORD CONSENT

Required for caregivers whose duties may include transporting residents, running errands, or driving a facility vehicle.

DRIVER'S LICENSE INFORMATION

Driver's License Number: State Issued:

Date of Issue: Expiration Date:

License Class: ☐ Operator (Class D) ☐ CDL ☐ Other:

Do you have current automobile insurance? ☐ Yes ☐ No

Insurance Carrier: Policy #:

DRIVING HISTORY

Has your driver's license ever been suspended, revoked, or restricted? ☐ Yes ☐ No

Have you been convicted of a DUI/DWI in the past 7 years? ☐ Yes ☐ No

Have you had any at-fault accidents in the past 3 years? ☐ Yes ☐ No

If you answered YES to any of the above, please explain:

CONSENT TO OBTAIN MOTOR VEHICLE RECORD

I authorize We Care Recovery BHRF to obtain a copy of my Motor Vehicle Record (MVR) from the Arizona Department of Transportation, or from any other state in which I currently hold or have held a driver's license, for purposes of evaluating my fitness for driving duties. I understand this authorization is valid for the duration of my employment and may be re-run periodically. I release We Care Recovery and any reporting agency from liability for obtaining and using this information.

SIGN

Applicant Signature: _____ Date: _____

Print Name: _____

FINGERPRINT CLEARANCE CARD CONSENT & AUTHORIZATION

In accordance with Arizona Revised Statutes § 36-411 and 9 A.A.C. 10, all personnel working in a Behavioral Health Residential Facility must possess a valid Arizona Fingerprint Clearance Card (FCC).

REQUIREMENTS

- Apply for FCC through Arizona DPS at https://psp.azdps.gov/
- Schedule fingerprinting at an authorized location
- Fee is applicant/employee responsibility unless otherwise indicated
- Processing takes 2–4 weeks; provide copy of valid FCC to We Care Recovery

FCC STATUS (check one):

☐ I have a valid FCC (attach copy)

FCC Number: _____

Expiration Date: _____

☐ I will apply for an FCC

Expected submission date: _____

ACKNOWLEDGMENT AND CONSENT

I understand that employment at We Care Recovery is contingent upon obtaining and maintaining a valid Arizona Fingerprint Clearance Card. I consent to verification of my FCC status and authorize We Care Recovery to access my FCC information through the Arizona DPS.

SIGN

Applicant Signature: _____ Date: _____

Print Name: _____

CENTRAL REGISTRY BACKGROUND CHECK CONSENT

In accordance with Arizona law and ADHS regulations, We Care Recovery is required to conduct a Central Registry Background Check on all personnel who will have contact with residents.

CONSENT AND AUTHORIZATION

I hereby authorize We Care Recovery and/or its designated agents to conduct a Central Registry Background Check.

I understand that:

- The Central Registry contains information about individuals investigated for abuse or neglect of children
- A substantiated finding may disqualify me from working with residents
- This authorization is valid for the duration of my employment
- I may request a copy of the results of this background check

Applicant Signature: _____ Date:

Print Name:

ADULT PROTECTIVE SERVICES REGISTRY VERIFICATION CONSENT

In accordance with House Bill 2764 and ADHS regulations effective July 1, 2024, We Care Recovery is required to verify the APS Registry status of all personnel prior to employment.

CONSENT AND AUTHORIZATION

I hereby authorize We Care Recovery to verify my status on the Arizona Adult Protective Services Registry prior to employment and periodically throughout my employment.

I understand that:

- Individuals listed on the APS Registry for substantiated abuse, neglect, or exploitation may be prohibited from working with vulnerable adults
- This authorization is valid for the duration of my employment
- A listing on the APS Registry may disqualify me from employment

Applicant Signature: _____ Date:

Print Name:

ABUSE/NEGLECT CERTIFICATION STATEMENT

Under Penalty of Perjury

I, (print name), hereby certify under penalty of perjury under the laws of the State of Arizona that the following statements are true and correct:

1. I have NEVER been convicted of, or pled guilty or no contest to, any crime involving abuse, neglect, or exploitation of a child, vulnerable adult, or individual with a disability.
2. I have NEVER had a substantiated finding of abuse, neglect, or exploitation against me by any state agency.
3. I am NOT currently under investigation for abuse, neglect, or exploitation by any state agency.
4. I have NEVER been denied a professional license, or had a license revoked or suspended, for reasons related to abuse, neglect, or exploitation.
5. I have NEVER been terminated from employment for reasons related to abuse, neglect, or exploitation.

I understand that providing false information may result in criminal prosecution, immediate termination, and civil liability.

Applicant Signature: _____ Date:

Print Name:

State of Arizona, County of

MANDATORY REPORTER ACKNOWLEDGMENT

Under A.R.S. § 46-454, healthcare professionals and persons responsible for the care of a vulnerable adult are mandatory reporters of suspected abuse, neglect, or exploitation.

ACKNOWLEDGMENT

I, _____ (print name), acknowledge and understand the following:

1. As a caregiver at We Care Recovery BHRF, I am a MANDATORY REPORTER under Arizona law.
2. I am required to immediately report any reasonable suspicion of abuse, neglect, exploitation, or self-neglect of a vulnerable adult to Adult Protective Services (1-877-SOS-ADULT / 1-877-767-2385) and/or local law enforcement.
3. I am required to immediately report any reasonable suspicion of abuse or neglect of a minor under A.R.S. § 13-3620 to the Department of Child Safety or law enforcement.
4. I will also notify the We Care Recovery Administrator of any report I make, as soon as practicable after the external report has been filed.
5. I understand that failure to report is a criminal offense under A.R.S. § 46-454 and § 13-3620 and grounds for immediate termination.
6. I understand that Arizona law protects good-faith reporters from civil and criminal liability.
7. I have received, or will receive within the first 30 days of employment, training on the indicators of abuse, neglect, and exploitation and on the proper reporting procedures.

SIGN

Applicant Signature: _____ Date: _____

Print Name: _____

TUBERCULOSIS (TB) SCREENING FORM

Per Arizona Administrative Code R9-10-113, all personnel must provide evidence of freedom from infectious TB.

CONTRACTOR INFORMATION

Name: _____ DOB: _____ Date: _____

TB SCREENING METHOD (Check one)

☐ Tuberculin Skin Test (Mantoux/PPD)

Date Administered: _____ Date Read: _____ Result (mm): _____

☐ Negative ☐ Positive

☐ IGRA Blood Test (QuantiFERON-TB Gold or T-SPOT.TB)

Date of Test: _____ Result: ☐ Negative ☐ Positive ☐ Indeterminate

☐ Chest X-Ray (Required if skin test or IGRA is positive)

Date of X-Ray: _____ Result: ☐ Normal ☐ Abnormal

Interpretation: _____

HEALTHCARE PROVIDER CERTIFICATION

I certify that the above-named individual has been screened for tuberculosis and:

☐ Is FREE from infectious tuberculosis and may work with residents

☐ Requires further evaluation/treatment before working with residents

SIGN

Provider Signature: _____ Date: _____

Provider Name (Print): _____ License #: _____

DRUG-FREE WORKPLACE & DRUG TESTING CONSENT

We Care Recovery BHRF is committed to maintaining a safe, drug-free environment for residents, staff, and visitors. As a behavioral health facility serving individuals in recovery, this commitment is especially critical.

DRUG-FREE WORKPLACE POLICY

I, _____ (print name), acknowledge and agree that:

1. I will not use, possess, manufacture, distribute, or sell any controlled substance or illegal drug on We Care Recovery property or while performing work duties.
2. I will not report to work under the influence of alcohol, illegal drugs, or any substance (including prescribed or over-the-counter medications) that impairs my ability to safely perform my duties.
3. I will notify the Administrator of any prescribed medication that may impair my ability to perform duties safely, prior to my next shift.
4. Violation of this policy is grounds for immediate termination.

DRUG & ALCOHOL TESTING CONSENT

I understand and consent that We Care Recovery may require drug and/or alcohol testing under the following circumstances:

- Pre-employment / pre-placement
- Reasonable suspicion of impairment
- Post-accident or post-incident
- Random testing
- Return-to-duty following a positive result or rehabilitation

I understand that refusal to submit to testing, or a confirmed positive result, may result in denial of employment or termination. I authorize the testing laboratory to release results to We Care Recovery and release We Care Recovery from any liability related to such testing.

SIGN

Applicant Signature: _____ Date: _____

Print Name: _____

CERTIFICATIONS CHECKLIST

Caregiver Name: _____ Date: _____

The following certifications are required for employment as a Caregiver:

CERTIFICATION REQUIREMENTS

CPR Certification

☐ Current ☐ Pending Cert #: _____ Exp. Date: _____

First Aid Certification

☐ Current ☐ Pending Cert #: _____ Exp. Date: _____

Arizona Driver's License

☐ Current ☐ N/A License #: _____ Exp. Date: _____

Food Handler's Card (Maricopa County)

☐ Current ☐ Pending ☐ N/A Cert #: _____ Exp.: _____

Article 9 / Direct Care Worker Training (if applicable)

☐ Current ☐ Pending ☐ N/A Provider: _____

Other professional licenses/certifications:

_____

CPR & First Aid must be obtained within 30 days of employment and renewed every 2 years. An Arizona Driver's License is required if duties include transporting residents.

I understand I am responsible for maintaining current certifications and providing updated documentation to We Care Recovery.

SIGN

Applicant Signature: _____ Date: _____

Print Name: _____

PREVIOUS EMPLOYMENT VERIFICATION RELEASE

Applicant Name: _____ SSN (last 4): _____

AUTHORIZATION

I hereby authorize We Care Recovery to contact any and all of my previous employers to verify my employment history and to obtain the following information:

- Dates of employment
- Position(s) held and job duties
- Reason for leaving
- Eligibility for rehire
- Job performance and conduct
- Any documented incidents involving residents, clients, or patients

I release We Care Recovery and all previous employers from any liability related to the exchange of this information.

SIGN

Applicant Signature: _____ Date: _____

Print Name: _____

EEO VOLUNTARY SELF-IDENTIFICATION

We Care Recovery BHRF is an Equal Opportunity Employer. We do not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, veteran status, genetic information, or any other characteristic protected by law.

Completion of this form is entirely VOLUNTARY. Refusal to provide it will not subject you to any adverse treatment. The information collected is used only for compliance reporting and is kept separate from your application.

GENDER

- ☐ Female
- ☐ Male
- ☐ Non-binary / Other
- ☐ Prefer not to answer

RACE / ETHNICITY (check all that apply)

- ☐ Hispanic or Latino
- ☐ White (Not Hispanic or Latino)
- ☐ Black or African American (Not Hispanic or Latino)

- ☐ Asian (Not Hispanic or Latino)
- ☐ Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)
- ☐ American Indian or Alaska Native (Not Hispanic or Latino)
- ☐ Two or More Races (Not Hispanic or Latino)
- ☐ Prefer not to answer

VETERAN STATUS

- ☐ I identify as a protected veteran
- ☐ I am not a protected veteran
- ☐ Prefer not to answer

DISABILITY STATUS

- ☐ Yes, I have a disability (or previously had one)
- ☐ No, I do not have a disability
- ☐ Prefer not to answer

SIGN

Applicant Signature: _____ Date: _____

Print Name: _____

JOB DESCRIPTION RECEIPT AND ACKNOWLEDGMENT

Position: Caregiver

ACKNOWLEDGMENT

I acknowledge that I have received a copy of the job description for the position of Caregiver at We Care Recovery BHRF.

I have read and understand the job description, including:

- Position summary and essential functions
- Required qualifications and certifications
- Physical requirements
- Work schedule requirements
- Reporting relationships
- Resident interaction expectations and professional boundaries

I understand that this job description is not all-inclusive and that I may be required to perform other duties as assigned.

SIGN

Caregiver Signature: _____ Date: _____

Print Name: _____

SIGN

Administrator Signature: _____ Date: _____

POLICIES AND PROCEDURES ACKNOWLEDGMENT

ACKNOWLEDGMENT

I acknowledge that I have received access to and/or copies of the following We Care Recovery policies:

- ☐ Employee Handbook

- ☐ Policies and Procedures Manual
- ☐ Resident Rights Policy
- ☐ Abuse/Neglect Prevention and Reporting Policy
- ☐ Zero-Tolerance Sexual Abuse Policy (G.3-A)
- ☐ Appropriate Displays of Affection Policy (G.5)
- ☐ Staff–Resident Interactions Outside Program Activities (G.6)
- ☐ Risk Management Policy (G.7)
- ☐ Emergency Procedures Manual
- ☐ HIPAA Privacy Policies
- ☐ Infection Control Policies
- ☐ Medication Administration Policies (if applicable)
- ☐ Grievance & Whistleblower Policy

I have read, or will read within 30 days of employment, all applicable policies and procedures. I understand and agree to comply with all policies and understand that violation may result in disciplinary action, up to and including termination.

SIGN

Caregiver Signature: _____ Date: _____

Print Name: _____

HIPAA & CONFIDENTIALITY AGREEMENT

As a caregiver at We Care Recovery BHRF, I will have access to Protected Health Information (PHI) and other confidential information about residents and the facility. The Health Insurance Portability and Accountability Act (HIPAA) and Arizona law require strict protection of this information.

AGREEMENT

I, _____ (print name), agree to the following:

1. I will access PHI only as required to perform my job duties. I will not access records of residents who are not assigned to me, even if I have technical ability to do so.
2. I will not disclose any PHI or confidential information to anyone outside We Care Recovery, including family, friends, social media, or any other third party, except as authorized in writing by the resident or required by law.
3. I will not discuss residents by name or in identifiable terms in any public space (hallways, elevators, parking lots, restaurants, etc.).
4. I will safeguard any PHI in my possession (paper or electronic) from unauthorized access, including by securing my workstation, locking files, and not sharing passwords.
5. I will not photograph, video record, or audio record any resident or any document containing PHI on a personal device.
6. I will not post, share, comment on, or otherwise reference any resident or facility matter on social media.
7. I will immediately report any actual or suspected breach of PHI to the Administrator or designated Privacy Officer.
8. My obligations under this agreement survive the termination of my employment and continue indefinitely.
9. I understand that violation may result in disciplinary action up to and including termination, civil penalties, and criminal prosecution under HIPAA (up to $50,000 per violation and up to 10 years imprisonment for malicious disclosure).

SIGN

Caregiver Signature: _____ Date: _____

Print Name:

ANTI-HARASSMENT & ANTI-DISCRIMINATION ACKNOWLEDGMENT

We Care Recovery BHRF is committed to a workplace free of harassment and discrimination of any kind, whether based on race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, genetic information, veteran status, or any other protected characteristic.

ACKNOWLEDGMENT

I, (print name), acknowledge that:

1. I have received and read the We Care Recovery Anti-Harassment and Anti-Discrimination Policy.
2. I understand that harassment includes unwelcome sexual advances, requests for sexual favors, sexually explicit jokes or imagery, slurs, intimidation, and other verbal or physical conduct based on a protected characteristic.
3. I will not engage in any such conduct toward any coworker, supervisor, resident, family member, vendor, or visitor.
4. If I experience, witness, or become aware of any such conduct, I will immediately report it to my supervisor, the Administrator, or the Owner. If the alleged harasser is the supervisor, I will report directly to the Administrator or Owner.
5. I understand that We Care Recovery prohibits retaliation against any person who reports harassment or participates in an investigation in good faith.
6. I understand that violation of this policy may result in disciplinary action up to and including immediate termination.

SIGN

Caregiver Signature: _____ Date:

Print Name:

CONFLICT OF INTEREST DISCLOSURE

Caregivers must avoid actual, potential, or perceived conflicts of interest with their duties to residents and to We Care Recovery BHRF.

DISCLOSURE QUESTIONS

1. Do you have any family members or close personal relationships with current residents of We Care Recovery? ☐ Yes ☐ No

2. Do you have any family members or close personal relationships with current employees, contractors, or owners? ☐ Yes ☐ No

3. Have you previously been a resident of We Care Recovery? ☐ Yes ☐ No

4. Have you previously had a personal (non-professional) relationship with anyone who is currently or has been a resident within the past 2 years? ☐ Yes ☐ No

5. Do you own, work for, or have a financial interest in any business that does or may provide services or goods to We Care Recovery (or its residents)? ☐ Yes ☐ No

6. Do you have a secondary job or business that could conflict with your hours or duties here? ☐ Yes ☐ No

If you answered YES to any of the above, please describe in detail:

AGREEMENT

I will promptly disclose to the Administrator any new conflict of interest that arises during my employment. I will not solicit, accept, or provide personal gifts, loans, or favors to or from residents. I will not enter into personal, romantic, sexual, or financial relationships with current residents or with former residents until at least two (2) years after discharge.

SIGN

Caregiver Signature: _____ Date:

Print Name:

INDEPENDENT CONTRACTOR AGREEMENT

This Independent Contractor Agreement ("Agreement") is entered into on _____, 20_____, by and between:

Company:

Address:

and

Contractor:

Address:

Collectively referred to as the "Parties."

1. SERVICES

Contractor agrees to perform the following services:

Contractor shall determine the manner, method, and means of performing the services, subject to the requirements and standards communicated by Company.

2. TERM

This Agreement shall begin on and shall continue until terminated by either Party in accordance with this Agreement.

3. COMPENSATION

Company shall pay Contractor as follows:

- ☐ $_____ per hour
- ☐ $_____ per project
- ☐ Other:

Contractor shall submit invoices as requested by Company. Payment shall be made within days of receipt of an approved invoice.

4. INDEPENDENT CONTRACTOR RELATIONSHIP

The Parties expressly agree that Contractor is an independent contractor and not an employee of Company.

Nothing in this Agreement shall be construed as creating an employer-employee relationship, partnership, joint venture, agency relationship, or franchise relationship between the Parties.

Contractor is solely responsible for all taxes, withholdings, insurance, licenses, permits, and other obligations arising from compensation received under this Agreement.

5. AVAILABILITY AND SCHEDULING

Contractor agrees to maintain general availability during the following periods:

Days:

Hours:

The Parties may modify these availability periods by mutual written agreement.

Company may offer assignments, projects, or service appointments that fall within Contractor's agreed availability. Once Contractor accepts an assignment, Contractor agrees to complete the assignment during the scheduled time period.

The establishment of availability periods is solely for scheduling and operational purposes and shall not be interpreted as creating an employment relationship or granting Company control over the manner and means by which Contractor performs the services.

6. NO GUARANTEE OF WORK OR HOURS

Contractor understands and agrees that Company does not guarantee any minimum number of assignments, projects, work hours, compensation, or earnings.

Work shall be assigned based upon business needs and client demand.

7. NO EMPLOYEE BENEFITS

Contractor acknowledges and agrees that they are not eligible for and shall not receive employee benefits from Company, including but not limited to:

- Health insurance
- Dental insurance
- Vision insurance
- Life insurance
- Disability insurance
- Workers' compensation coverage provided by Company
- Retirement or pension benefits
- Paid vacation
- Paid sick leave
- Holiday pay
- Overtime pay
- Unemployment benefits
- Any other employee benefit offered by Company

Contractor is solely responsible for obtaining and maintaining any insurance coverage desired or required by law.

8. EQUIPMENT AND EXPENSES

Unless otherwise agreed in writing, Contractor shall provide all equipment, tools, supplies, transportation, and materials necessary to perform the services.

Contractor shall be responsible for all expenses incurred while performing services under this Agreement.

9. CONFIDENTIALITY

Contractor shall maintain the confidentiality of all non-public information obtained through the performance of services and shall not disclose such information except as authorized by Company or required by law.

This provision survives termination of this Agreement.

10. OWNERSHIP OF WORK PRODUCT

Any work product, documents, materials, reports, or deliverables specifically created for Company under this Agreement shall become the property of Company upon payment in full for such work.

Contractor agrees to execute any documents reasonably necessary to confirm Company's ownership rights.

11. COMPLIANCE WITH LAWS

Contractor shall comply with all applicable federal, state, and local laws, regulations, licensing requirements, and industry standards related to the services provided.

12. INDEMNIFICATION

Contractor agrees to indemnify, defend, and hold harmless Company, its owners, officers, employees, and agents from any claims, damages, liabilities, costs, or expenses arising out of Contractor's negligence, misconduct, breach of this Agreement, or violation of law.

13. TERMINATION

Either Party may terminate this Agreement at any time by providing _____ days' written notice.

Company may terminate this Agreement immediately for material breach, misconduct, violation of law, or failure to perform services as agreed.

Upon termination, Contractor shall be paid for approved services performed through the effective termination date.

14. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with the laws of the State of _____.

15. ENTIRE AGREEMENT

This Agreement contains the entire understanding between the Parties and supersedes all prior agreements, discussions, or understandings regarding the subject matter herein.

Any amendment must be in writing and signed by both Parties.

16. SIGNATURES

COMPANY

Company Signature: _____ Date: _____

Name: _____ Title: _____

CONTRACTOR

Contractor Signature: _____ Date: _____

Name: _____

FORM I-9 EMPLOYMENT ELIGIBILITY VERIFICATION

Section 1 — Employee Information and Attestation

(To be completed by employee on first day of employment)

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____

State: _____ ZIP: _____ DOB: _____ SSN: _____

Email: _____

Phone: _____

I attest, under penalty of perjury, that I am (check one):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States
- ☐ A lawful permanent resident (Alien Reg. #: _____)
- ☐ An alien authorized to work until: _____ (USCIS #: _____)

Employee Signature: _____ Date: _____

Section 2 — Employer Review (within 3 business days of start date)

List A Document OR List B + List C Documents:

Document Title:
Document #:
Issuing Authority:
Expiration:
First Day of Employment:
Employer: We Care Recovery BHRF | 9129 S 48th Dr, Laveen, AZ

Employer Signature: _____ Date:

ARIZONA FORM A-4 — EMPLOYEE'S WITHHOLDING ELECTION

EMPLOYEE INFORMATION

Name: SSN:
Address: City/State/ZIP:

ARIZONA WITHHOLDING PERCENTAGE ELECTION (choose ONE)

- ☐ 0.5% (Smallest withholding)
- ☐ 1.0%
- ☐ 1.5%
- ☐ 2.0%
- ☐ 2.5%
- ☐ 3.0%
- ☐ 3.5% (Largest withholding)
- ☐ Zero Withholding Election — I elect 0% AND I certify that I expect to have no Arizona income tax liability for this year (my Arizona taxable income is expected to be less than $15,000 single / $30,000 married filing jointly).

ADDITIONAL WITHHOLDING (Optional)

I elect to have an additional amount withheld: $

Per pay period.

CERTIFICATION

I certify that the information on this form is correct.

Employee Signature: _____ Date:
Print Name:

DIRECT DEPOSIT AUTHORIZATION

CONTRACTOR INFORMATION

Name: SSN (last 4):
Address: Phone:

PRIMARY ACCOUNT (Required)

Bank Name:
Routing Number: Account Number:
Account Type: ☐ Checking ☐ Savings
Deposit Amount: ☐ 100% of Net Pay OR $ per pay period

SECONDARY ACCOUNT (Optional)

Bank Name: _____

Routing Number: _____ Account Number: _____

Account Type: ☐ Checking ☐ Savings Amount: $ _____ per pay period

AUTHORIZATION

I hereby authorize We Care Recovery BHRF to initiate electronic deposits to the account(s) listed above. I also authorize the financial institution(s) to accept these deposits. This authorization remains in effect until I provide written cancellation notice.

☐ I have attached a voided check or deposit slip for verification

Contractor Signature: _____ Date: _____

Print Name: _____

For Payroll Use — Effective Date: _____ Processed By: _____

AT-WILL EMPLOYMENT ACKNOWLEDGMENT

I, _____ (print name), acknowledge and understand the following:

1. EMPLOYMENT RELATIONSHIP: My employment with We Care Recovery BHRF is "at-will." This means that either I or We Care Recovery may terminate the employment relationship at any time, with or without cause, and with or without notice.
2. NO EMPLOYMENT CONTRACT: I understand that this acknowledgment is not a contract of employment, either express or implied. No supervisor, manager, or representative of We Care Recovery has the authority to enter into any agreement for employment for any specified period of time.
3. MODIFICATION OF AT-WILL STATUS: The at-will nature of my employment can only be modified by a written agreement signed by me and the Administrator/Owner of We Care Recovery.
4. POLICIES AND PROCEDURES: We Care Recovery may modify, revoke, suspend, terminate, or change any policies, procedures, benefits, or practices at any time, with or without notice.
5. ARIZONA LAW: I understand that Arizona is an at-will employment state, and this acknowledgment is consistent with Arizona employment law.

ACKNOWLEDGMENT

I have read this At-Will Employment Acknowledgment and understand that my employment with We Care Recovery BHRF is at-will.

Employee Signature: _____ Date: _____

Print Name: _____

Administrator Signature: _____ Date: _____

EMERGENCY CONTACT INFORMATION FORM

CONTRACTOR INFORMATION

Name: _____ Phone: _____

Address: _____ City/State/ZIP: _____

PRIMARY EMERGENCY CONTACT

Name: Relationship:

Phone (Primary): Phone (Alt):

Email:

SECONDARY EMERGENCY CONTACT

Name: Relationship:

Phone (Primary): Phone (Alt):

Email:

MEDICAL INFORMATION (Optional, for emergency response only)

Allergies:

Medical Conditions:

Current Medications:

Preferred Hospital:

Primary Care Physician (Name/Phone):

AUTHORIZATION

I authorize We Care Recovery to contact the individuals listed above in case of an emergency and to share this information with emergency medical personnel if necessary.

SIGN

Contractor Signature: _____ Date:

Print Name:

APPLICANT CERTIFICATION & SIGNATURE

THIS IS A LEGALLY BINDING DOCUMENT. PLEASE READ CAREFULLY BEFORE SIGNING.

APPLICANT CERTIFICATION

I, (print full legal name), hereby certify that:

1. All information I have provided in this application packet — including personal information, education, employment history, references, criminal history, certifications, and all consent and acknowledgment forms — is true, complete, and accurate to the best of my knowledge.
2. I have not knowingly omitted any information that would be material to We Care Recovery's evaluation of my fitness for the position of Caregiver.
3. I understand that any false statement, misrepresentation, or omission discovered before or after hire will be grounds for refusal of employment or immediate termination, regardless of when discovered.
4. I authorize We Care Recovery BHRF and its designated agents to investigate any and all information contained in this application, including but not limited to: contacting prior employers, references, educational institutions, and licensing authorities; obtaining criminal history, motor vehicle, and Central Registry / APS Registry information; and conducting any other inquiries that are lawful and relevant to my fitness for the position.
5. I release We Care Recovery, its agents, and any person or entity providing information from any and all liability arising from the provision and use of such information for employment purposes.
6. I understand that this application does not create a contract of employment, that any employment offered is at-will, and that any offer is contingent upon successful completion of all background checks, fingerprint clearance, TB screening, and other pre-employment requirements.
7. I understand that I am required to inform We Care Recovery immediately of any change in my eligibility, certifications, license status, criminal history, or any other information contained in this application during the course of my employment.

Signed under penalty of perjury under the laws of the State of Arizona.

Applicant Signature: _____ Date: _____

Print Name: _____

Witnessed By (Administrator or HR): _____

Date: _____

APPLICATION PACKET COMPLETION CHECKLIST

For Administrator Use Only

Applicant Name: _____ Date Received: _____

APPLICATION DOCUMENTS RECEIVED

- ☐ General Caregiver Information (completed)
- ☐ Education History (completed and signed)
- ☐ Employment History (completed and signed)
- ☐ Professional References (3 references provided and signed)
- ☐ Criminal History Disclosure (signed)
- ☐ Driver's License & MVR Consent (signed)
- ☐ Fingerprint Clearance Card Consent (signed)
- ☐ Central Registry Background Check Consent (signed)
- ☐ APS Registry Verification Consent (signed)
- ☐ Abuse/Neglect Certification Statement (signed)
- ☐ Mandatory Reporter Acknowledgment (signed)
- ☐ TB Screening Form (completed by provider)
- ☐ Drug-Free Workplace & Drug Testing Consent (signed)
- ☐ Certifications Checklist (completed)
- ☐ Previous Employment Verification Release (signed)
- ☐ EEO Voluntary Self-Identification (provided or declined)
- ☐ Job Description Acknowledgment (signed)
- ☐ Policies and Procedures Acknowledgment (signed)
- ☐ HIPAA & Confidentiality Agreement (signed)
- ☐ Anti-Harassment & Anti-Discrimination Acknowledgment (signed)
- ☐ Conflict of Interest Disclosure (signed)
- ☐ Independent Contractor Agreement (signed)
- ☐ Form I-9 (completed)
- ☐ Federal Form W-4 (attached, completed, and signed)
- ☐ Arizona Form A-4 (completed)
- ☐ Direct Deposit Authorization (completed)
- ☐ At-Will Employment Acknowledgment (signed)
- ☐ Emergency Contact Information (completed)
- ☐ Application Certification & Signature (signed)

ATTACHMENTS RECEIVED

- ☐ Copy of AZ Fingerprint Clearance Card

- ☐ Copy of AZ Driver's License
- ☐ Copy of Auto Insurance (if driving residents)
- ☐ Copy of CPR Certification
- ☐ Copy of First Aid Certification
- ☐ Copy of High School Diploma / GED / College Diploma
- ☐ Copy of Professional License(s) / Certifications
- ☐ Copy of Social Security Card
- ☐ Voided Check or Deposit Slip
- ☐ Resume / CV

BACKGROUND CHECKS COMPLETED

FCC verified Date: _____ Initials: _____

APS Registry check Date: _____ Initials: _____

Central Registry check Date: _____ Initials: _____

MVR check (if applicable) Date: _____ Initials: _____

Employment references Date: _____ Initials: _____

Education verification Date: _____ Initials: _____

Drug screen Date: _____ Initials: _____

FINAL DETERMINATION

- ☐ Applicant approved for hire — Start date: _____
- ☐ Applicant conditionally approved — Pending: _____
- ☐ Applicant denied — Reason: _____

SIGN

Administrator Signature: _____ Date: _____