

# Certified Nursing Assistant



**PROGRAM COST: \$425.00**

**You may qualify for a scholarship to cover the costs of your classes, and you may also be eligible for assistance with transportation expenses, living expenses, interview outfits, and more! To find out...**

**Please bring the following items when you turn in your application:**

- \_\_\_ **Driver's License or State Issued ID Card**
- \_\_\_ **Birth Certificate**
- \_\_\_ **Social Security Card**
- \_\_\_ **Proof of income for the last 6 months for all household members**
- \_\_\_ **12 month billing history from utility companies**
- \_\_\_ **Copies of current utility bills**
- \_\_\_ **Record of military services or benefits for surviving spouses or dependents**

**Absence of any of these items may result in your denial to participate in this program**

**We look forward to helping you!**



Cornerstone Community Action Agency  
114 Needham  
Coleman, TX 76834  
(325) 625-4167 (325) 625-3335 (fax)



## CNA Benefits Program

The CNA Benefits Program is different from the CNA Program. This program can help to offset the cost and, if you qualify, can render the course free of charge. This program is income based, and each applicant will be screened for eligibility.

All completed applications (**with required documentation**) must be delivered in person to Central Texas Opportunities, Inc. (CTO) located at Coleman County State Bank, 118 West Pecan, Suite 405 Coleman, Texas. **No application will be considered unless all documentation is included.**

- Qualifying CNA students may be eligible for \$500.00 in childcare reimbursement during CNA classes.
  - Care provider cannot be spouse or individual living in the home
- Qualifying CNA students may be eligible to receive funds to cover testing fees.
- Qualifying CNA students may be eligible to receive fuel cards for travel to and from CNA testing site and Clinical locations.
  - Students may receive one (1) \$25 gas card for one (1) round trip travel to Abilene for CNA testing or up to four (4) round trips to Brownwood for clinical. Carpooling is encouraged.
- Qualifying CNA students may be eligible for assistance in purchasing uniforms and some equipment not to exceed \$100.00.



## Cornerstone Community Action Agency

114 Needham Street | Coleman, TX 76834

Email: [mail@ctoinc.org](mailto:mail@ctoinc.org)

Phone: (325)625-4167 | Fax: (325) 625-3335

### **Intake Application**

#### **PLEASE PROVIDE COPIES OF THE FOLLOWING WITH THE COMPLETED APPLICATION:**

**PLEASE REMEMBER:** Applications are processed in the order they are received and by a priority rating scale. Until your application is processed, you are required to continue to pay your utility bill until you receive a confirmation letter from CCAA notifying you of services received.

- ☐ 1. **Picture ID** for everyone age 18 and over (Driver's License, Identification Card, etc.)
- ☐ 2. **Proof of US Citizenship** for everyone in the Household (Birth Certificates, USA Passport, Green Card, Naturalization Certification, Asylum Seeker Certificate)
- ☐ 3. **Secondary Proof of Citizenship** such as Voter Registration Card, School Photo ID, School Record (showing name of child, address and parents' names), Hospital Birth Record etc.
- ☐ 4. **Social Security Cards** for ALL household members (if applicable).
- ☐ 5. **Proof of all income** earned/received in the last thirty (30) days for all household members 18 years and older, such as:
  - a. ☐ Checks stubs: 5 stubs if paid weekly, 3 stubs if paid bi-weekly, 2 stubs if paid twice a month or 1 stub if paid monthly. **Do not submit W2 Tax forms.**
  - b. ☐ Current year Award Letter(s) (Social Security, SSD, VA, TANF, SSI, etc.)
  - c. ☐ Current year Pension or retirement Statements
  - d. ☐ Receipt Book if paid in cash
  - e. ☐ Child Support Statement
  - f. ☐ Unemployment Income Statement
  - g. ☐ Declaration of Income Statement; if there is no income in the household or you are unable to get the documentation.(Form included and must be signed)
- ☐ 6. **Current utility bills and last 12-month billing history** (front and backside) for: Electric, Gas or propane. Account must be active (not disconnected).
- ☐ 7. **Signed Systematic Alien Verification for Entitlements (SAVE) Form.** (Form included)

**Allow 30 – 90 days for processing. Incomplete Applications will cause a delay in service.**

Other Services offered at Cornerstone Community Action Agency (CCAA)



Veterans General Assistance  
and Home Repair



Case Management



C N A Program  
(Certified Nursing Assistance)



Home Buying and  
Rental Assistance



Retired and Senior  
Volunteer Program



Payee Services



Keeping the Warmth  
Purchase of Gas Appliances and repairs  
for Atmos Customers



Heating and Cooling

CCAA is proud to offer **FREE** tax preparation assistance. Through our Volunteer Income Tax Assistance (VITA) program, trained volunteers are able to process your tax return...**for free!**



***Tell us how we're doing! Please go to [www.ctoinc.org](http://www.ctoinc.org) and complete a quick client satisfaction survey***



## Intake Application

### FOR OFFICE USE ONLY

Received \_\_\_\_\_  
 \_\_\_\_VA \_\_\_\_Priority  
 \_\_\_\_CM \_\_\_\_N Priority

<b>Name:</b>		<b>Phone:</b>		<b>Email:</b>	
<b>Physical Address:</b>				<b>Apt #:</b>	
<b>City/State/Zip:</b>				<b>County:</b>	
<b>Mailing Address (if different from physical):</b>				<b>Apt #:</b>	
<b>City/State/Zip:</b>					
(Circle One) Own * Rent * Other Permanent Housing * Homeless * Other				<b>Are you a:</b> Farmer <input type="checkbox"/> Migrant <input type="checkbox"/> seasonal farm worker <input type="checkbox"/> Other <input type="checkbox"/>	
<b>Alternate Contact Name:</b>		<b>Relationship:</b>		<b>Phone:</b>	

<b>Priority Information</b>	<b>Yes</b>	<b>No</b>
Have you ever received services from Cornerstone Stone Community Action Agency or CTO in the past?		
Is anyone in the household 60 years of age or older?		
Is anyone in the household disabled?		
Are there any children 5 years or younger in the household?		
Is anyone in the home a veteran?		
Is anyone living in your household age 14-24 that is not going to school or working? If yes, Who		
Are you or anyone in your household interested in increasing income and education levels ?		

<b>Conflict of Interest Information:</b>	<b>Yes</b>	<b>No</b>
Is anyone in the household currently an employee, agent, consultant, officer or board member of Cornerstone Community Action Agency? If YES, identify who and their position		
Is anyone in the household related to anyone currently serving as an employee, agent, consultant, officer or board member of Cornerstone Community Action Agency? If YES, identify who and their position _____		
<b>FOR OFFICE USE ONLY:</b> If there is a Conflict of Interest, this application requires the Executive Director's Approval signature before processing for assistance with any program with in CCAA Executive Director signature _____ Date _____		

## INTAKE APPLICATION

**Dear Applicant:**

The information on this form is needed to determine your household's eligibility. Please complete this entire form and leave **no blanks**.

Household Member Name	Relationship To Applicant  Self Spouse Child Sibling Grandchild Friend Other	Social Security Number	Race  American Indian White Black or African American Native Hawaiian or Pacific Islander White Multi-race Alaskan Native Asian Other	Hispanic or Latino  Y or N	Gender  Male or Female	Date of Birth			Age	Disabled  Y or N	Type of Insurance  Direct-Purchased Employment based Medicaid Medicare Military Health Card State Children's Health Insurance	Education  0-8 9-12/Non-Grad HS Grad/GED 12+Post Secd. College 2or4 Yr Grad. Grad or other post-sec. school
						Mo	Day	YR				
1.	SELF											
2.												
3.												
4.												
5.												
6.												
7.												

**Note:** Use additional sheets if there are more than seven members living in the household

## Intake Application

### Sources of Household Income

List ALL income of adults and children that are 18 years of age or older for the Past 30 days)

#### INCOME FROM EMPLOYMENT

(Please explain who in the home is employed or self-employed and how often they are paid)

<b>Household member name:</b>		<b>Household member name:</b>
How often paid?		How often paid?
Monthly   Weekly   Twice Month   Three Times Month		Monthly   Weekly   Twice Month   Three Times Month
<b>Household member name:</b>		<b>Household member name:</b>
How often paid?		How often paid?
Monthly   Weekly   Twice Month   Three Times Month		Monthly   Weekly   Twice Month   Three Times Month

#### OTHER SOURCES OF INCOME

Please identify income (circle yes or no)

VA Service Connected	Yes	No		Spousal support / Alimony	Yes	No
VA Non-Service Connected	Yes	No		Unemployment income	Yes	No
Social Security Disability (SSDI)	Yes	No		Utility Subsidy	Yes	No
VA retirement pension	Yes	No		TANF	Yes	No
Social Security supplemental income (SSI)	Yes	No		Workers Compensation	Yes	No
Retirement from Social Security (SS)	Yes	No		Child support	Yes	No
Pension	Yes	No		If Other, Explain:	Yes	No

#### NON-CASH BENEFITS

Identify income from any of the following sources: (circle yes or no and give amount)

SNAP	Yes	No	Amount:	\$
WIC	Yes	No	Amount:	\$
LIHEAP	Yes	No	Amount:	\$
Housing Choice Voucher (Section 8)	Yes	No	Amount:	\$
Public Housing (HUD)	Yes	No	Amount:	\$
Permanent Supportive Housing	Yes	No	Amount:	\$
HUD-VASH (Veterans ONLY)	Yes	No	Amount:	\$
Childcare Voucher	Yes	No	Amount:	\$
Affordable Care Act Subsidy	Yes	No	Amount:	\$
Other	Yes	No	Amount:	\$

## Intake Application

Housing Information						
Where do you live (Circle correct one)	Do you own or pay rent		Monthly Rent or Mortgage amount	Are the Utilities included?		
Private Home	Own	Rent	\$	Yes	No	
Mobile Home	Own	Rent	\$	Yes	No	
Apartment	Own	Rent	\$	Yes	No	
Subsidized or Public housing		Rent	\$	Yes	No	
Shelter or transitional housing		Rent	\$	Yes	No	
With a friend or family member or in a Motel		Rent	\$	Yes	No	

### Landlord/ Mortgage information:

<b>Name:</b>	<b>Phone:</b>
<b>Address:</b>	<b>City, State, Zip:</b>

### Energy Efficiency Information

	Yes	No
Do you need home repair or weatherization?		
Has home been weatherized in the past? If so when?		
What year was your home build? _____ Do you live in a double wide?		
Does your roof leak? If yes, How long? _____ How many rooms leak? _____		
What condition is the floor and foundation? Explain:		

### UTILITY INFORMATION

Electric Service Vendor:	Account #	Heating Cooling Both
Natural Gas Service Vendor:	Account #	Heating Cooling Both
Propane Service Vendor:	Account #	Heating Cooling Both
Water Vendor:	Account #	Heating Cooling Both
Type of A/C: (circle one) Central unit   Evaporative cooler   Window Unit   None	Type of Heater: (circle one) Central unit   Electric Heater   Fireplace   Space Heater   Wall Furnace   None	

### VETERAN INFORMATION

1. Are you, or anyone in the household a Veteran, Surviving Spouse of a Veteran, or a Dependent of a Veteran? Yes No	
If yes, please identify which household member and circle the category that describes them.	
Household Member Name: _____ Veteran   Surviving Spouse of a Veteran   Dependent of a Veteran	
2. Have you ever served in the National Guard? (circle one) Yes No	
3. Have you ever served in the Military, excluding ROTC? (circle one) Yes No	



## Intake Application

### SITUATION DOCUMENTATION

**Note: Services cannot be provided unless this page is completed**

Please tell us what your personal or family financial situation is documenting why you need assistance:

If there is no household income in the last 30 days how have you been living with no income? What sources are you using to pay for rent, utilities and/or other necessities? \_\_\_\_\_

When was the last income received and where did it come from? \_\_\_\_\_

### Authorizations

1. The information provided is true and correct to the best of my knowledge and belief.
2. I understand that my **gross household income** is annualized at the time of application according to pre-established agency rules and procedures in order to receive assistance.
3. I understand that I may request a hearing to appeal a denial of eligibility, amount of assistance received, or a delay in service delivery.
4. I authorize the Texas Department of Housing and Community Affairs and Cornerstone Community Action Agency to solicit/verify information including employment verification needed to provide assistance with my utilities and/or fuel bills, both past and future.
5. I am an applicant of Cornerstone Community Action Agency I hereby give my permission to release and verify all information requested and understand that it will be kept in strict confidence to be used for program purposes only. I understand that photocopy of this release is as valid as the original and may be used to obtain employment information or verify other data.
6. I give permission for pictures to be taken for identification purposes, projects, publication, newsletter and promotional activities Cornerstone Community Action Agency. I give permission for my comments to be used in projects, publications, newsletter and/or promotional activities for Cornerstone Community Action Agency
7. I understand **that if I change utility companies I must notify the family advocate for my county within 5 business days** of my new utility company and account number with the name on the account. **If I do not notify Cornerstone Community Action Agency of my new utility company I will lose any payments due. When the information is provided any remaining assistance may be reinstated depending on available funding.**
8. If you or another member of the household has no income the Declaration of No Income sheet must be completed for all household members over 18 years of age having no income. On this sheet do not include anyone who has shown income on the application.
9. **I UNDERSTAND THAT I AM SUBJECT TO PROSECUTION FOR PROVIDING FALSE OR FRAUDULENT INFORMATION ON THIS APPLICATION AND I ALSO UNDERSTAND THAT RECEIPTOR ASSISTANCE THROUGH MISREPRESENTATION OR FRAUD IS PUNISHABLE BY FINE OR IMPRISONMENT.**

Applicant's Signature

Date

CCAA, Staff Member

Date

## **NEEDS ASSESSMENT**

**Please indicate what needs you have below by circling either “yes” or “no” in each box.  
If you circle “yes”, please explain the need you’re experiencing so that we can help you.**

SERVICE	NEED	Client Explain	SERVICE	NEED	Client Explain
Basic Needs: Food, Clothing, Food Stamps, WIC, Meals on Wheels, Emergency, Other	Yes No		Counseling: Family, Alcohol/Substance Abuse, Other	Yes No	
Income: SSD, TANF, SS, SSI, VA, Child Support, Budget, Other	Yes No		Transportation: To Work, Dr. Appointment, Other	Yes No	
Employment: Looking for a Job, Job Search Assistance, Resume, Other	Yes No		Veteran’s Needs: Medical, Training, Home Repairs, Handicap Accessibility, Other	Yes No	
Utility Assistance: Gas/Propane, Water, Electric, Other	Yes No		Legal Needs: Child support, Criminal, Civil, Other	Yes No	
Housing Needs: Temporary Shelter, low income housing, Rent Assistance, Weatherization, Repairs, Other	Yes No		Health Needs: Immunizations, Medication, Mental Health Services, Other	Yes No	
Heating/Cooling Assistance: Heaters, Window Units, Repairs, Hot Water Heater, Natural Gas Piping/Repairs	Yes No		Education: GED, English as a Second Language, Vocation/Tech training, Other	Yes No	
Child Care/ Elderly Care, Other	Yes No		Other needs not identified on assessment	Yes No	

# TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

## Systematic Alien Verification for Entitlements (SAVE) System and US Citizenship/US National Applicant Certification Form for WAP and CEAP



The program for which you are applying requires verification that you are a U.S. citizen, a non-citizen national, or a legal resident of the United States. Documentation of your status is required. This agency uses the Systematic Alien Verification for Entitlements (SAVE) System to verify the status of non-citizens.

Household Member Name	U.S. Citizen (Born or Naturalized) or U.S. National (Yes/No)	Qualified Alien (Yes/No)	Documentation Provided for:	
			Status	Identification

To add additional household members, use another copy of this form.

I AM AWARE THAT I AM SUBJECT TO PROSECUTION FOR PROVIDING FALSE OR FRAUDULANT INFORMATION.		
<b>Applicant's Signature</b>		<b>Date</b>
<b>Signature of agency staff certifying they verified the above documents</b>	<b>Print Staff Name</b>	<b>Date</b>

Updated March 2019 Previous Versions Obsolete

## COMMUNITY SERVICES

# Self-Certification of Disability

Applicant's Name:	
Name of Person with Disability:	
Relationship of Person with Disability to Applicant:	

### **Persons with Disabilities--Any individual who is:**

- A handicapped individual as defined in §7(9) of the Rehabilitation Act of 1973;
- Under a disability as defined in §1614(a)(3)(A) or §223(d)(1) of the Social Security Act or in §102(7) of the Developmental Disabilities Services and Facilities Construction Act; or
- Receiving benefits under 38 U.S.C. Chapter 11 or 15.

### **APPLICANT'S AUTHORIZATION TO DECLARE DISABLED STATUS:**

I hereby authorize for the purpose of confirming my eligibility as a Person with Disability, in accordance with the above-stated definition of Person with Disability.

\_\_\_\_\_  
Signature of Person with Disability or His/Her Guardian

\_\_\_\_\_  
Date

## DECLARATION OF INCOME STATEMENT (DECLARACION DE INGRESOS)

Applicant Name (Nombre del Solicitante)	Applicant Last Name (Apellido)	Suffix (Sufijo)
Address (Dirección)	City (Ciudad)	Zip Code (Código Postal)

State the gross income for household members, 18 years and older, who have no documentation of the income received in the **30 day period** prior to the date of application for assistance: *(Declarar el ingreso recibido por los miembros de su hogar, que tienen 18 años de edad ó mas, y que no tienen documentación de ingresos por los 30 días antes del aplicar para asistencia)*

Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)
Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)
Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)
Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)

My household has no documented proof of income due to the following situation:  
*(Mi hogar no tiene prueba para documentar los ingresos por medio de tal razones):*

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I certify that the above information is true and correct to the best of my knowledge and belief. *(Yo certifico que la información proveída de los ingresos es verdadera y correcta según mi saber y creencia.)*

I understand that the information will be verified to the extent possible; and that I may be subject to prosecution for providing false or fraudulent information. *(Comprendo que la información será verificada hasta donde sea posible y que puedo ser enjuiciado por haber proveído información falsa ó fraudulenta.)*

\_\_\_\_\_  
*(Applicant Signature/Firma del Solicitante)*

\_\_\_\_\_  
*(Date/Fecha)*



## For ATMOS Clients Only

### CLIENT CONSENT AND RELEASE OF INFORMATION

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MAACLink is a computer system that is used locally as a Homeless Management Information System (HMIS). Use of an HMIS is required by the US Department of Housing and Urban Development (HUD) for agencies that receive HUD funding. MAACLink is not electronically connected to HUD and is only used by authorized agencies. All MAACLink users have received confidentiality training and have signed strict agreements to protect clients' personal information and limit its use appropriately.

A Privacy Notice is available at participating agencies. It provides details on how member agencies and their employees handle client information and data sharing.

I give permission to **Cornerstone Community Action Agency** (Agency Name) to collect and enter my personal and household information into the MAACLink computer system.

I understand that the MAACLink system is shared with and used by authorized agencies in my community for the purposes of:

1. Assessing the needs of low-income, homeless or other special-needs people in order to give better assistance and to improve their current or future situations.
2. Improving the quality of care and service for people in need.
3. Tracking the effectiveness of community efforts to meet the needs of people who have received assistance.
4. Reporting data on an aggregate level that does not identify specific people or their personal information.

I understand that:

- Information I give about my physical or mental health will NOT be shared outside the agency I am working with.
- I have the right to view my MAACLink file with an authorized user.
- Signing this release form does not guarantee that I will receive assistance.
- I may revoke my authorization by completing a revocation form.
- All agencies that use MAACLink will treat my information with respect and in a professional and confidential manner.
- Unauthorized people or organizations cannot gain access to my information without my consent.
- If I receive services from Homeless Prevention Rapid Re-Housing Federal Stimulus (HPRP) Funds, my information may be viewed by other participating agencies across Continuums of Care.

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Client Name (Printed)

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Client Signature

---

Date

---

Agency Representative Name (Printed)

---

Agency Representative Signature

---

Date



Central Texas Opportunities, Inc.  
Intake Application Addendum

**Applicant Information**

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

Are you a citizen of the United States? ☐ Yes ☐ No

If no, are you authorized to work in the US? ☐ Yes ☐ No

Have you ever been convicted of a felony? ☐ Yes ☐ No

If yes, explain: \_\_\_\_\_

Have you ever been convicted of a misdemeanor? ☐ Yes ☐ No

If yes, explain: \_\_\_\_\_

**Education**

High School: \_\_\_\_\_ Address: \_\_\_\_\_

From: \_\_\_\_\_ to \_\_\_\_\_

Did you graduate? ☐ Yes ☐ No

**References**

*Please list two references*

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

**Previous Employment**

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Job Title: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ to \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_



Central Texas Opportunities, Inc.  
Intake Application Addendum

**Previous Employment (continued)**

Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Job Title: \_\_\_\_\_  
Responsibilities: \_\_\_\_\_  
From: \_\_\_\_\_ to \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**Miscellaneous Information**

1. Write a brief summary about why you want to become a Certified Nursing Assistant.

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

2. What do you want to get out the Certified Nursing Assistant Course?

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

3. How will you apply the Certified Nursing Assistant certification to your future jobs/life/goals?

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

4. Write a brief summary about you that would make you stand out against other applicants.

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

**Disclaimer and Signature**

*I certify that my answers are true and complete to the best of my knowledge.  
If this application leads to selection, I understand that false or misleading information in my  
application or interview may result in my release.  
I certify that I will put forth all effort necessary to attend the scheduled class times for this  
certification.  
I certify that I will maintain all HIPAA requirements if I am selected for the Certified Nursing  
Assistant course.*

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

Print Name: \_\_\_\_\_



# Customer Assessment

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

TWIST ID: \_\_\_\_\_

Please read and answer the following questions as they apply to you. Your responses are optional and will be used to help us customize your services. All information is confidential.

TWIST Screens	Question	Yes	No
IC	1. Are you a migrant or seasonal farmworker?		
IC	2. Do you have a misdemeanor? Additional Info: _____		
IC	3. Do you have a felony? Additional Info: _____		
AOQ	4. Are you currently on probation? Additional Info: _____		
AOQ	5. Are you currently on parole? Additional Info: _____		
AOQ	6. Do you need legal advice or assistance? Additional Info: _____		
AOQ	7. Are there legal limitations to the type of employment you can accept? Additional Info: _____		
AOQ	8. Are there legal limitations to the job search methods you can use? Additional Info: _____		
IC	9. Are you homeless? (This means you do not have a regular home of your own and are living somewhere temporarily, such as a shelter or with other people you know.)		
IC	10. Do you have difficulty reading, writing, or speaking in the English language?		
IC	11. Are you under 18 years old and away from your regular home because you have run away?		
IC	12. Are you under 22 years old and either pregnant or have children of your own?		
IC	13. Are you now or were you formerly under the care of foster parents?		
IC	14. Highest grade in school completed:		
IC	15. Do you have a high school diploma?		
IC	16. Are you attending school? ? If the answer is yes, please provide additional information in the comments section on the last page.		
IC	17. Do you have any training certifications or degrees? Additional Info: _____		
IC	18. Are you a military veteran?		

TWIST Screens	Question	Yes	No
IC	19. Are you currently receiving any of the following types of assistance? <input type="checkbox"/> TANF <input type="checkbox"/> SNAP <input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Other assistance_____		
IC	20. Check the box that most accurately describes your family: <input type="checkbox"/> I am a parent in a 1-parent family <input type="checkbox"/> I am a parent in a 2-parent family <input type="checkbox"/> I live with my family but am not a parent <input type="checkbox"/> I live alone or live with people who are not family members		
IC	21. I am a parent, but my child(ren) does not live with me.		
IC	22. Check the box that applies to your marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married but separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
IC	23. Total number of people who live in your household: _____		
IC	24. I am available for work.		
IC	25. I am: <input type="checkbox"/> Employed <input type="checkbox"/> Employed but received a notice of termination <input type="checkbox"/> Unemployed		
IC	26. I am receiving unemployment compensation. ____Regular ____Extended		
IC	27. Check the box(es) that applies to you. <input type="checkbox"/> I have a disability. <input type="checkbox"/> My disability is related to military service. <input type="checkbox"/> I do not have a disability. <input type="checkbox"/> I do not wish to disclose whether I do or do not have a disability.		
AOQ	28. Do you need help with child care to work, look for work, or attend school?		
AOQ	29. Do you need help with getting clothes that are appropriate for work or looking for work?		
AOQ	30. Do you need food?		
AOQ	31. Do you need help with getting necessary medical care, or paying for medical care?		
AOQ	32. Do you need emergency housing?		
AOQ	33. Do you need help paying for rent or utilities?		
AOQ	34. Do you need help obtaining a personal identification document such as a driver's license, identification card, or social security card?		
AOQ	35. Do you need gas money, a bus pass, or rural transit ticket?		
AOQ	36. Do you need help with car repairs?		
AOQ	37. Do you have any other needs connected with your ability to get or keep a job that are not otherwise mentioned on this form? If so, please record in the comments section below.		

TWIST Screens	Question	Yes	No
AOQ	38. What types of work are you interested in? <hr/> <hr/> <hr/>		
AOQ	39. What are your job skills/abilities? <hr/> <hr/> <hr/> <hr/>		
AOQ	40. Other information you want to share that could impact your ability to get or keep a job. <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
AOQ	41. Additional Comments/Information <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		

Please list your last 3 jobs, beginning with the most recent.

Begin Date	End Date	Employer (and contact name)	Full-Time or Part-Time?	Job Title
Salary	Hours	Address (street, city, zip)	Phone	Reason for Leaving
Job Duties:				

Begin Date	End Date	Employer (and contact name)	Full-Time or Part-Time?	Job Title
Salary	Hours	Address (street, city, zip)	Phone	Reason for Leaving
Job Duties:				

Begin Date	End Date	Employer (and contact name)	Full-Time or Part-Time?	Job Title
Salary	Hours	Address (street, city, zip)	Phone	Reason for Leaving
Job Duties:				

## **Coleman County Medical Center HIPAA Acknowledgement Consent**

I have been asked by ***Coleman County Medical Center*** (herein referred to as “the Hospital”) to reaffirm my commitment made at the time of my assignment to protect the confidentiality of health information. I understand that the Hospital reminds its employees and volunteers of their confidentiality obligations on a periodic basis to help ensure compliance, due to the significance of this issue. By my signature below, I acknowledge that I made the commitment set forth below at the time of my assignment, I confirm my past compliance with it, and I reaffirm my continued obligation to it.

The Hospital and Nursing Homes has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my assignment at the Hospital, I may come into possession of confidential patient information, even though I may not be directly involved in providing patient services.

I understand that such information must be maintained in the strictest confidence. As a condition of my assignment, I hereby agree that, unless directed by my instructor, I will not at anytime during or after my assignment with the Coleman County Medical Center Certified Nursing Aide Program disclose any patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient information, other than as necessary in the course of my assignment.

When patient information must be discussed with other health care practitioners in the course of my work, I will use discretion to ensure that such conversations cannot be overheard by others who are not involved in the patient’s care.

☐ I understand that violation of this agreement may result in corrective or disciplinary action, up to and including involuntary discharge,

☐ I understand I could receive a personal fine for disclosing personal health information.

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Print Name

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Date

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Signature

## INVESTIGATION FOR CRIMINAL CONVICTIONS

1. I understand that my employment is temporary until an investigation is made to see if I have a conviction for a felony or misdemeanor for certain types of offenses. A complete listing of the offenses is located in the facility policy for Criminal Background Checks.
2. I understand that Texas DPS Criminal records; Nurse Aide Registry and Misconduct Registry will all be accessed for any record of violation that could bar employment from this facility.
3. I understand that I will be immediately terminated if I have a conviction for an offense like those listed in Chapter 250 of the Health and Safety Code, or listed under the current facility policy.
4. I understand that I must provide the following listed information for purposes of the facility to assist in completing a background investigation.
5. The Misconduct Registry is a tracking system conducted by the DADS that maintains a listing of any individual that has committed the act of abuse, neglect, exploitation, or misappropriation. This facility will check this registry prior to hire and are prohibited from hiring anyone that is listed on the registry.
6. I have been informed that I may request a copy of the facility policy for criminal history checks.

Below are some of the offenses that may bar employment. This listing is not all-inclusive of the offenses that may bar employment. For a full listing please review the facility policy on Criminal Background Checks.

Criminal Homicide Kidnapping Unlawful Restraint Indecent Exposure Indecency with a Child Assault Aggravated Assault Sexual Assault Improper relationship between educator and student Injury to a Child, Elderly Individual or Disabled Individual Deadly Conduct Sale/Purchase of Child Abandoning or Endangering Child Agreement to Abduct from Custody Terroristic Threat Aiding Suicide Arson Robbery/Aggravated Robbery Online Solicitation of a Minor Money Laundering Medicaid Fraud Cruelty to Animals Burglary Theft False Identification as a Peace Officer Misapplication of Fiduciary Property of a Financial Institution Securing execution of a Document of Deception Disorderly Conduct

Please Type or Print Legibly:

Name (Last, First, Middle)		Other Names/ Alias (Married, Maiden)	
Social Security No.	Date of Birth (mo/day/yr)	Sex: Male____ Female____	
Race/Ethnicity Black____ White____ Other____		Signature:	
		Date:	

**Facility Instructions:** Use the above information to complete The Criminal History Check Form.  
Place this copy in the Employee's personnel file.

### ~FOR FACILITY USE ONLY~

Do Not Hire List Checked	Date_____	By_____
Findings: <input type="checkbox"/> Employable	<input type="checkbox"/> Not Employable	
OIG State Website Checked	Date_____	By_____
Findings: <input type="checkbox"/> Employable	<input type="checkbox"/> Not Employable	
OIG Gov. Website Checked	Date_____	By_____
Findings: <input type="checkbox"/> Employable	<input type="checkbox"/> Not Employable	
Nurse Aide Registry Checked	Date_____	By_____
Findings: <input type="checkbox"/> Employable	<input type="checkbox"/> Not Employable	
Misconduct Registry Checked	Date_____	By_____
Findings: <input type="checkbox"/> Employable	<input type="checkbox"/> Not Employable	
Criminal History Checked	Date_____	By_____
Findings: <input type="checkbox"/> Employable	<input type="checkbox"/> Not Employable	

Comments: \_\_\_\_\_

# DPS Computerized Criminal History (CCH) Verification

## (AGENCY COPY)

I, \_\_\_\_\_, acknowledge that a Computerized Criminal

APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB identifiers I supply. (This is not a consent form.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history, therefore the organization conducting the criminal history check is not allowed to discuss with me any criminal history record information obtained using this method. The agency may request that I have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search. Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

In order to complete the process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at [www.txdps.state.tx.us /Crime Records/Review of Personal Criminal History](http://www.txdps.state.tx.us/Crime%20Records/Review%20of%20Personal%20Criminal%20History) or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of \$24.95 to the fingerprinting services company.

**(This copy must remain on file by your agency. Required for future DPS Audits)**

\_\_\_\_\_  
Signature of Applicant or Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Name (Please print)

\_\_\_\_\_  
Agency Representative Name (Please print)

\_\_\_\_\_  
Signature of Agency Representative

\_\_\_\_\_  
Date

**Please:  
Check and Initial each Applicable Space**

CCH Report Printed:

YES \_\_\_\_\_ NO \_\_\_\_\_ \_\_\_\_\_ initial

Purpose of CCH: \_\_\_\_\_

Empl \_\_\_\_ Vol/Contractor \_\_\_\_ \_\_\_\_\_ initial

Date Printed: \_\_\_\_\_ \_\_\_\_\_ initial

Destroyed Date: \_\_\_\_\_ \_\_\_\_\_ initial

**Retain in your files**

**Privacy Acknowledgement and Non-Disclosure Agreement**  
**Employee Scope of Access to Resident Personal Health Information**

We are committed to protecting the privacy of all Resident and protecting the confidentiality of their health care information. The following specific principles are applicable to all of the facility employees, independent health care professional involved in the care of residents, volunteers, students, faculty, vendors and contractors regardless of their job classification or position while working with resident at or for the facility, I realize that I may have access to or become aware of confidential resident medical information, whether or not I am directly involved in providing care to that resident I understand that I must keep this information in the strictest of confidence. As a condition of my employment or work at the facility, I agree that I:

- Will not verbally or in any written form disclose confidential resident medical information except, as needed to perform the duties of my job,
- Will not knowingly include or cause to be included in any record or report, a false, inaccurate, or misleading entry,
- Will not remove or copy any record or report from the office where it is kept except in the performance of my duties,
- Will report any violation of this policy.

If I have access to computerized information or programs at the nursing home, I understand that the information accessed through all facility information systems contains sensitive and confidential resident care, business, financial, and facility employee information that should *only* be disclosed to those authorized to receive it I commit to:

- Respect the ownership of proprietary software,
- Respect the finite capability of the systems, and limit my own use so as not to interfere unreasonably with the activity of other users,
- Respect the procedures established to manage the use of the system,
- Prevent unauthorized use of any information in files maintained, stored or processed by the facility,
- Not operate any non-licensed software or any computer provided by the facility,
- Not utilize anyone else's authentication code or device in order to access any facility's system,
- Respect the confidentiality of any reports printed from any information system containing resident/member information and handle, store and dispose of these reports appropriately,
- Not release my authentication code,
- Understand that all access to the system will be monitored,
- Understand that my computer system privileges hereunder are subject to periodic review, revision and if appropriate, renewal.

I understand that a violation of this Agreement may result in corrective action up to and including termination of my employment for the facility and that my obligations under this Agreement will continue after termination of my employment at the facility. By signing this, I agree that I have read, understand and will comply with the facility's policies concerning the confidentiality of information and use of computerized information systems and the statements made in this Agreement.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

**HR New Hire From #20**