



Community Best Care LLC does not discriminate on the basis of disability in employment or in the admission or access to, or treatment, or employment in, its programs, services, or activities.

# Pre-Employment Questionnaire

1. Are you currently employed    YES        NO

If yes will you be giving a notice to your employer?    YES or NO

2. Date you will be available to work \_\_\_\_\_

3. Are you willing to travel?        YES        NO

If yes how far are you willing to travel ? \_\_\_\_\_

4. Are you willing to work in a home with the following:

Dogs	YES	NO
Cats	YES	NO
Smokers	YES	NO
Males	YES	NO
Females	YES	NO
Children	YES	NO

Hours Available

Mon \_\_\_\_\_ to \_\_\_\_\_  
 Tues \_\_\_\_\_ to \_\_\_\_\_  
 Weds \_\_\_\_\_ to \_\_\_\_\_  
 Thur \_\_\_\_\_ to \_\_\_\_\_  
 Fri \_\_\_\_\_ to \_\_\_\_\_  
 Sat \_\_\_\_\_ to \_\_\_\_\_  
 Sun \_\_\_\_\_ to \_\_\_\_\_

5. Are you available for fill ins?    YES        NO

6. Are you available for weekend care ?    YES        NO

7. Are you available for holidays?        YES        NO

8. Do you have reliable transportation?    YES        NO

9. Will your hours need adjusted because of children or schooling? YES    NO

If so explain:

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10. Are you wanting full-time or part-time?        FULL    PART

11. Maximum hours per week \_\_\_\_\_

12. Minimum hours per week \_\_\_\_\_

13. How did you hear about this position?

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

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Date

**Community Best Care**  
**400 Harrison St. Suite 204**  
**Batesville, AR. 72501**  
**(870) 569-8082**

Company		Phone (    )
Address		Supervisor
JobTitle	Starting Salary	Ending Salary
Responsibilities		
Dates of Employment	From	To
Reason for leaving:		
May we Contact this employer?		

Company		Phone (    )
Address		Supervisor
JobTitle	Starting Salary	Ending Salary
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**Community Best Care**  
**400 Harrison St. Suite 204**  
**Batesville, AR. 72501**  
**(870) 569-8082**

May we Contact this employer?

Please summarize your qualifications or special skills:

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By signing this application you agree to provide Community Best Care LLC a recent Drug Test and authorize Community Best Care LLC to have the Arkansas State Police to conduct a complete background check. NO Independent contractor (caregiver) will be placed with a Client until the background check has been completed and returned to Community Best Care LLC by the Arkansas State Police and Drug Screening has been completed provided to Community Best Care LLC.

I certify that my answers are true and complete to the best of my knowledge. I authorize Community Best Care LLC to make any investigations and inquiries into my personal employment, educations, financial, Police background, and medical history including drug screening as may be necessary for a contract decision. I hereby release any employer, school, or individual from any and all liability when responding to any inquiries in connection with my application.

IN THE EVENT I AM SELECTED, I UNDERSTAND THAT ANY FALSE OR MISLEADING STATEMENTS GIVEN IN MY APPLICATION OR INTERVIEW(S) MAY RESULT IN MY IMMEDIATE LOSS OF CONTRACT.

\_\_\_\_\_  
NAME

\_\_\_\_\_  
DATE

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## References

*Please list three professional references.*

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

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

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

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

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

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

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

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

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



400 Harrison Street Suite 204  
Batesville, AR. 72501  
870-569-8082

**AUTHORIZATION FORM FOR MVR REVIEW**

I understand that it is my responsibility to operate my vehicle in a safe manner and to drive defensively to prevent injuries and property damage.

I also understand that Community Best Care, LLC will periodically review my Motor Vehicle Record to determine continued eligibility as a caregiver. In accordance with the Fair Credit Reporting Act, I have been informed that a Motor Vehicle Record will be periodically obtained on me for continuance of my status as an independent contractor.

I acknowledge the receipt of the above disclosure and authorize Community Best Care or its designated agent to obtain a Motor Vehicle Record report. This authorization is valid as long as I am contracted with Community Best Care.

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

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

SS#: \_\_\_\_\_

\_\_\_\_\_  
Driver's License Number

\_\_\_\_\_  
State

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewer's Signature

\_\_\_\_\_  
Date

**PRE-EMPLOYMENT BACKGROUND CHECK AUTHORIZATION**

I, \_\_\_\_\_, understand that as part of the employment process, Community Best Care, LLC needs to complete a background check on me regarding:

- |                                      |  |
|--------------------------------------|--|
| 1. Criminal record;                  | 6. Motor Vehicle Records;                        |
| 2. Sex and Violent Offenders Record; | 7. Personal/Professional Reference Verification; |
| 3. Employment Verification;          | 8. Medical Suitability                           |
| 4. Education Verification;           | 9. Drugs/Alcohol                                 |
| 5. License Verification;             |  |
- ☐ I authorize all federal and state agencies, persons and organizations that may have information relevant to this research to disclose such information to Community Best Care, LLC or its authorized agent(s).
  - ☐ I understand that this authorization is to be part of the written and signed employment application.
  - ☐ I also understand that I do not have to give authorization for a background check but if I don't give permission, my employment application will not be processed further.
  - ☐ I understand that I have specific rights under the federal Fair Credit Reporting Act (FCRA) and may have additional rights under relevant State law.
  - ☐ I further authorize that a photocopy of this authorization may be considered as valid as the original.
  - ☐ I hereby certify that all statements on this form are true and correct to the best of my knowledge and belief. I understand that employment with Community Best Care, LLC is contingent upon successful completion of a background check.

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

Full Name \_\_\_\_\_ Telephone No. \_\_\_\_\_

Former Name(s) used: \_\_\_\_\_

Current Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Current Driver's License: \_\_\_\_\_ State: \_\_\_\_\_