Cheney Care Center
Employment Application

APPLICANT INFORMATION			
Last Name:	First:	M.I.	Date:
Street Address:		Apartment/Unit #:	
City:	State:	ZIP:	
Phone No.:	E-mail Address:		
Date Available:		Desired Salary:	
Position Applied for:			
Are you able to provide proof of your ability to work in the United States? YES ☐ NO ☐			
Have you ever worked for this company? YES ☐ NO ☐	If yes, when?		
Do you have any responsibilities or commitments that may prevent you from meeting work and attendance requirements?			
Where did you hear about Cheney Care Center?			

WORK DESIRED					
What prompted you to apply for a position with us?					
Can you rotate shifts? YES ☐ NO ☐					
Full Time ☐	Part Time ☐	Any Shifts ☐	Days ☐	Evenings ☐	Night Shift (NOC) ☐

EDUCATION			
High School:		City/State	
Did you graduate? YES ☐ NO ☐			Degree:
College:		Address:	
From	To	Did you graduate? YES ☐ NO ☐	Degree:
Other:		Address:	
From	To	Did you graduate? YES ☐ NO ☐	Degree:

PROFESSIONAL REGISTRATION OR CERTIFICATION

If you do not have a required registration or license, have you applied for one? *YES* ☐ *NO* ☐

Human Resources Only	Type of registration or certificate	State	Number

EMPLOYMENT HISTORY
List all employers beginning with your present/most recent employer, then previous employers in order, attach a separate sheet or resume if you have had more than four employers.

Company:				Phone:
Address:				Supervisor:
Job Title:				
Responsibilities:				
From:	To:	Reason for Leaving:		
May we contact your previous supervisor for a reference? YES ☐ NO ☐				
Company:				Phone:
Address:				Supervisor:
Job Title:				
Responsibilities;				
From:	To:	Reason for Leaving:		
May we contact your previous supervisor for a reference? YES ☐ NO ☐				
Company:				Phone:
Address:				Supervisor:
Job Title:				
Responsibilities:				
From:	To:	Reason for Leaving:		
May we contact your previous supervisor for a reference? YES ☐ NO ☐				
Company:				Phone:
Address:				Supervisor:
Job Title:				
Responsibilities:				
From:	To:	Reason for Leaving:		
May we contact your previous supervisor for a reference? YES ☐ NO ☐				

Describe your work experience?

____

____

____

What would you like to be doing in five years?

____

____

____

What type of work do you find to be most interesting?

____

____

____

What type of work do you dislike most?

____

____

____

Cheney Care Center/Cheney Assisted Living/Cheney Home Care does not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, sexual orientation, national origin, age disability, marital status, veteran status, or any other characteristic protected by law. Cheney Care Center/Cheney Assisted Living/Cheney Home Care is an Equal Opportunity/Affirmative Action Employer.

REFERENCES

Please list four professional adult references, Not related to you

Full Name:	Years Known:	Email Address:
Company:	Phone No.:	
Address:		
Full Name:	Years Known:	Email Address:
Company:	Phone No.:	
Address:		
Full Name:	Years Known:	Email Address:
Company:	Phone No.:	
Address:		

Additional information about you which would aid us in our employment decision?______________________________

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____

DISCLAIMER AND SIGNATURE

I hereby certify that the information contained on this application form is true, accurate and my complete employment history. I authorize Cheney Care Center/Cheney Assisted Living/Cheney Home Care to contact any of my schools or former employers, except those I have indicated, for a complete account of their experience with me. I understand that if I am employed, any misrepresentation of facts on this application or during the interview is sufficient cause for dismissal. I also understand that I must successfully complete any medical tests/examinations that are required by Cheney Care Center/ Cheney Assisted Living/ Cheney Home Care. I also understand that, regardless of personal preference, I might be called upon to rotate to a different shift should the needs of the facility require a change.

Signature:	Date:

APPLICANT VOLUNTARY SELF-IDENTIFICATION INFORMATION

As a federal government contractor, we are requesting information about race, gender, and veteran status in order to comply with government reporting requirements and in order to ensure equal employment opportunity. We consider all applicants for positions without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. We also comply with all applicable laws including E.O. 11246, as amended, and the Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended (VEVRAA), governing employment practices and do not discriminate on the basis of any unlawful criteria.

In an effort to comply with requirements regarding government recordkeeping, reporting, and other legal obligations, which may apply, we invite you to complete this applicant data survey. Submission of this information is voluntary and will be kept confidential. Failure to provide information will not subject you to any adverse personnel decision or action. Your cooperation is appreciated.

Position: ______________________________________ Date: ___________________________

GENDER

☐ MALE ☐ FEMALE ☐ I DECLINE TO ANSWER

RACE/ETHNICITY

☐ WHITE (not Hispanic or Latino)
☐ HISPANIC OR LATINO
☐ BLACK or AFRICAN AMERICAN (not Hispanic or Latino)
☐ ASIAN (not Hispanic or Latino)
☐ NATIVE HAWAIIAN or PACIFIC ISLANDER (not Hispanic or Latino)
☐ AMERICAN INDIAN/ALASKA NATIVE (not Hispanic or Latino)
☐ TWO or MORE RACES (not Hispanic or Latino)
☐ I DECLINE TO ANSWSER

VETERANS STATUS

This company is also subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment veterans in the following classifications:

- A "disabled veteran" is one of the following:
  - a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
  - a person who was discharged or released from active duty because of a service-connected disability.
- A "recently separated veteran" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
- An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- An "Armed forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. As a Government contractor subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

☐ I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS OF PROTECTED VETERAN LISTED ABOVE
☐ I AM NOT A PROTECTED VETERAN
☐ DECLINE TO ANSWER

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name: Date:
Employee ID:
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

- ☐ Yes, I have a disability, or have had one in the past
- ☐ No, I do not have a disability and have not had one in the past
- ☐ I do not want to answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.
For example:
Job Title: Date of Hire:

CHENEY CARE CENTER

2219 North 5th St.
Cheney, WA 99004-2199
(509)235-6196 (509)235-2044 Fax

Reference Request

Attention: ____

Name: ____ has applied to our facility for employment. Please complete the appropriate section below and fax back to us at your earliest convenience. Your prompt attention is appreciated. Thank you.

Position Held:__________________________________Dates Employed: From___________to__________

Release:

I hereby release from all liability the company or the person completing this from, and authorize them to release all information regarding my fitness for employment to Cheney Care Center. I understand that I may revoke this authorization, in writing, at any time. I also understand that I may not maintain an action against the person, institution, company or entity or any other person giving information in good-faith reliance on an authorization without actual notice of the revocation of the authorization.

Applicant's Signature:____Date:__________________

Employment Reference: Is the above employment information correct?

Yes____No_____(If no, please explain.) ____

____

	Above Average	Average	Below Average
Job Knowledge	☐	☐	☐
Cooperation	☐	☐	☐
Dependability, Attendance	☐	☐	☐
Quality of Care	☐	☐	☐
Getting along with others	☐	☐	☐

Would you rehire this person? Yes ☐ No ☐ (If no, please explain.)

Other information: ____

____

Signature:____ Date:_____________________

Title/or Relationship to Applicant: ____

Grievance Procedure that Incorporates Due Process Standards

Section 1557 of the Affordable Care Act Grievance Procedure

It is the policy of Cheney Care Community not to discriminate on the basis of race, color, national origin, sex, age or disability. Cheney Care Community has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Human Resources, 2219 N 6th St, Cheney, WA 99004, Phone (509) 235-6196, Fax (509) 235-2044, who has been designated to coordinate the efforts of Cheney Care Community to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Cheney Care Community to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Cheney Care Community relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 1557 Coordinator's decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Cheney Care Community will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Dated: 12-07-2016

http://www.hhs.gov/civil-rights/for-providers/clearance-medicare-providers/example-grievance-procedure/

Notice About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement: Discrimination is Against the Law

Cheney Care Community complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cheney Care Community does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cheney Care Community:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Human Resources

If you believe that Cheney Care Community has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Human Resources, 2219 N. 6th St, Cheney Wa 99004, (509)235-6196.You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Human Resources is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file.

Taglines For Individuals With Limited English Proficiency of Language Assistance Services

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-5092356196.

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 – 5092356196

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-5092356196.

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-5092356196번으로 전화해 주십시오.

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-5092356196.

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-5092356196.

Ukrainian УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-5092356196.

Mon-Khmer, Cambodian ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-5092356196។

Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-5092356196 まで、お電話にてご連絡ください。

Amharic ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-5092356196.

Cushite XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-5092356196.

Arabic ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-5092356196 (رقم هاتف الصم والبكم: 1-xxx-xxx-xxxx).

Panjabi ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-5092356196 'ਤੇ ਕਾਲ ਕਰੋ।

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-5092356196.

Laotian ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-5092356196.

PAY TRANSPARENCY

NONDISCRIMINATION PROVISION

The contractor will not discharge or in any other manner discriminate against employees or applicants because they have inquired about, discussed, or disclosed their own pay or the pay of another employee or applicant. However, employees who have access to the compensation information of other employees or applicants as a part of their essential job functions cannot disclose the pay of other employees or applicants to individuals who do not otherwise have access to compensation information, unless the disclosure is (a) in response to a formal complaint or charge, (b) in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the employer, or (c) consistent with the contractor's legal duty to furnish information. 41 CFR 60-1.35(c)

If you believe that you have experienced discrimination contact OFCCP
1.800.397.6251 | TTY 1.877.889.5627 | www.dol.gov/ofccp