



If you have the latest version of Adobe Reader, please complete the following THP job application on your computer screen. Click or tab through the areas that you need to enter information. When you are finished, you have the option to:

**MAIL** the job application to:

**The Health Plan**

ATTN: Carla Bell, PHR, SHRM-CP  
Senior Vice President of Human Resources  
1110 Main Street  
Wheeling, WV 26003-2704

**FAX** the job application to:

**740.699.6256**

The Health Plan ATTN: Carla Bell, PHR, SHRM-CP  
Senior Vice President of Human Resources

OR **EMAIL** the job application to:

[hr@healthplan.org](mailto:hr@healthplan.org)

Carla Bell, Senior Vice President of Human Resources

In the subject line of the email, please type: **APPLICATION**

(To email the job application, you will need to go to 'File,' 'Save As,' and select PDF. Save the file on your computer in an area where you will remember where it is located. Open your email program, compose your email and attach the PDF document you just saved. Hit 'Send'.)



# THE HEALTH PLAN EMPLOYMENT APPLICATION

Please type or print.

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

POSITION APPLYING FOR:

Applications are active for six months.

The Health Plan is an EO employer. Qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, disability or protected veteran status.

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ (voluntary)

Present Address: \_\_\_\_\_ LAST FIRST MI Home Phone \_\_\_\_\_  
 \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 \_\_\_\_\_ Work Phone \_\_\_\_\_  
 \_\_\_\_\_ CITY STATE ZIP Email Address \_\_\_\_\_

Best time to contact you at home: \_\_\_\_\_  am  pm

Are you at least 18 years of age?  Yes  No *Proof of citizenship or immigration status will be required upon employment.*

Immigration Status: Are you eligible to work in the U.S.?  Yes  No

Under what other name(s) can background information be obtained? \_\_\_\_\_

Have you ever been *convicted* of a felony?  Yes  No If yes, please explain where, when, and disposition of case below:

*NOTE: A conviction will not necessarily be a bar to employment. Factors such as date, nature and number of offenses, age at the time of offense, and rehabilitation will be considered.*

Have you ever filed an application with us before?  Yes  No If yes, give date: \_\_\_\_\_

Have you ever been employed with us before?  Yes  No If yes, give date: \_\_\_\_\_

Are you related to anyone currently working at this facility?  Yes  No

If yes, please give his/her name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Are you currently employed?  Yes  No

May we contact your present employer?  Yes  No

Are you currently on "lay-off" status and subject to recall?  Yes  No

How did you hear about this position?  Advertisement  Employment Agency  Friend  Internet  
 HP Website  Inquiry  Relative  Other: \_\_\_\_\_

Can you travel if this job requires it?  Yes  No

PERSONAL

THE HEALTH PLAN IS AN EO EMPLOYER - VETERANS/DISABLED AND OTHER PROTECTED CATEGORIES  
THE HEALTH PLAN PARTICIPATES IN E-VERIFY

POSITION

Position(s) Desired: \_\_\_\_\_  
Clinical Specialty \_\_\_\_\_  
Preference(s): \_\_\_\_\_

Date available to work: \_\_\_\_\_ What is your desired salary range? \_\_\_\_\_

Are you available to work: (check all that apply)  Full Time  Part Time

If Part Time, indicate hours per week you are able to work: \_\_\_\_\_

Are you able to work weekends and holidays?  Yes  No

**SKILLS**

Word Processing  Yes  No

Medical Terminology  Yes  No

Spreadsheets  Yes  No

CPT Coding  Yes  No

Database  Yes  No

ICD-10  Yes  No

Foreign Language  Yes  No

Please list foreign language(s): \_\_\_\_\_  Read  Speak  Write

\_\_\_\_\_  Read  Speak  Write

\_\_\_\_\_  Read  Speak  Write

Please list other office machines you can operate skillfully:

\_\_\_\_\_

Please state any additional specialized information you may feel helpful in considering you for this position:

\_\_\_\_\_

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

*You may exclude membership which would reveal gender, race, religion, national origin, age, ancestry, disability or other protected status.*

\_\_\_\_\_

**DO NOT ANSWER THIS QUESTION UNLESS YOU HAVE BEEN INFORMED ABOUT THE REQUIREMENTS FOR THIS POSITION!**

Can you perform the essential functions of the job, for which you are applying, either with or without a reasonable accommodation?  Yes  No

LICENSE

**PROFESSIONAL LICENSE, REGISTRATION, CERTIFICATION**

Do you have a professional license?  Yes  No  Nursing  Marketing  Other, list: \_\_\_\_\_

State information:  Ohio Ohio License/Registration # \_\_\_\_\_ Expiration date \_\_\_\_\_

West Virginia WV License/Registration # \_\_\_\_\_ Expiration date \_\_\_\_\_

Other, list state and # \_\_\_\_\_ Expiration date \_\_\_\_\_

If license is not in Ohio, have you applied?  Yes  No Date Applied: \_\_\_\_\_

If license is not in WV and is required, have you applied?  Yes  No Date Applied: \_\_\_\_\_

REFERENCES	PERSONAL / PROFESSIONAL REFERENCES <i>(Do not include family members)</i>					
	<u>COMPANY / OCCUPATION</u>	<u>NAME</u>	<u>PHONE NUMBER</u>	<u>BEST TIME TO CALL</u>	<u>Supervisor?</u>	
	1.				<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> Current <input type="checkbox"/> Former
	2.				<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> Current <input type="checkbox"/> Former
3.				<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> Current <input type="checkbox"/> Former	

EDUCATION	HIGH SCHOOL	Name / Address	Course of Study	Years Completed	Diploma / Degree
	COLLEGE, etc.	Name / Address	Course of Study	Years Completed	Diploma / Degree
	GRADUATE SCHOOL	Name / Address	Course of Study	Years Completed	Diploma / Degree
CONTINUING EDUCATION COURSES COMPLETED WITHIN THE LAST TWO YEARS					
1			Date Completed:	Units Earned:	
2			Date Completed:	Units Earned:	
3			Date Completed:	Units Earned:	

EMPLOYMENT HISTORY	List employment beginning with your present or last job. Include any job-related military service assignments and volunteer activities. You may exclude organizations which indicate race, color, religion, gender; national origin, disabilities or other protected status.						
	1	Employer		From Date	To Date	Job Title and Responsibilities	
		Address					
			Street	ST	ZIP		
		Supervisor					
		Phone					
		Reason for Leaving					
					May we contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2	Employer		From Date	To Date	Job Title and Responsibilities	
		Address					
		Street	ST	ZIP			
Supervisor							
Phone							
Reason for Leaving							
				May we contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

EMPLOYMENT HISTORY CONTINUED

3	Employer		From Date	To Date	Job Title and Responsibilities	
	Address					
		Street	ST	ZIP		
	Supervisor					
	Phone					
	Reason for Leaving					
					May we contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No

4	Employer		From Date	To Date	Job Title and Responsibilities	
	Address					
		Street	ST	ZIP		
	Supervisor					
	Phone					
	Reason for Leaving					
					May we contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No

COMMENTS: Include explanation of any gaps in employment.

AUTHORIZATION (Please read carefully before signing.)

I authorize The Health Plan of West Virginia, Inc., (The Health Plan), to verify any information I have provided and I further authorize any of the named schools, companies or persons listed to provide any information about me contained in their records. I understand and agree that any misrepresentation, falsification or omissions by me in this application may be sufficient cause for disqualification of the application and/or separation from The Health Plan if I have since been employed. My signature below hereby authorizes disclosure of information and releases The Health Plan, its officers, agents and employees from liability for such disclosure.

I understand that if employed by The Health Plan, my first 90 calendar days will be on an introductory basis. As an employee, I agree to abide by all rules and regulations of The Health Plan.

I recognize The Health Plan's right to require a drug test. I further understand that submitting to various tests is a condition of my employment, and I agree to cooperate in their administration. I understand that my employment may be contingent upon verification by any state or federal government agency for Medicare or Medicaid false claims, fraud or abuse. In the event any such investigation is initiated, I will immediately notify The Health Plan.

I further understand that The Health Plan is a "tobacco/smoke free campus" and no use of tobacco products is permitted within the facilities or on the campus of The Health Plan, including parking lots and vehicles on company property.

I understand that should I be hired for the position for which I am applying, or any subsequent position, either The Health Plan or I may terminate the working relationship at any time and for any reason. I understand that no contract may be made orally, regardless of the reliance of the employee on such statements made by any manager at The Health Plan. I further understand that if employed, my wages and position may change, but my status as an employee-at-will will never change during my employment. Completion and/or submission of this application does not constitute an offer of employment.

DATE: \_\_\_\_\_ Signature: \_\_\_\_\_

By checking this box I agree that the typed name I have entered above will be the electronic representation of my signature.

## Voluntary Self-Identification of Disability

Form CC-305  
Page 1 of 1

OMB Control Number 1250-0005  
Expires 05/31/2023

Name: \_\_\_\_\_  
Employee ID: \_\_\_\_\_  
(if applicable)

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

### Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at [www.dol.gov/ofccp](http://www.dol.gov/ofccp).

### How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

### Please check one of the boxes below:

- Yes, I Have A Disability, Or Have A History/Record Of Having A Disability
- No, I Don't Have A Disability, Or A History/Record Of Having A Disability
- I Don't Wish 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.

## VOLUNTARY PRE-EMPLOYMENT SELF-IDENTIFICATION FORM

(Please answer all questions - Please Print)

It is the policy of The Health Plan of West Virginia, Inc. to provide equal employment opportunity to all qualified applicants for employment without regard to race, color, religion, national origin, gender, age, veteran status or disability. This company is subject to certain nondiscrimination and affirmative action record-keeping and reporting requirements which require us to invite job applicants to voluntarily complete this self-identification form. All information collected will be kept strictly confidential and may only be used in accordance with the provisions of applicable federal laws and regulations, including those which require the information to be summarized and reported to the federal government for civil rights enforcement purposes. Completion of this form is voluntary and will not affect the decision regarding your application for employment. This Pre-Employment Information Form will be kept in a Confidential File separate from the attached Employment Application.

Do not hesitate to ask for assistance if you have any difficulty completing this form.

Position(s) applied for: \_\_\_\_\_

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

Name: \_\_\_\_\_  
First Name Middle Name Last Name

Address: \_\_\_\_\_  
Street City, State Zip Code

Gender:  Male  Female

Are you Hispanic or Latino?  Yes  No

If not, what race do you consider yourself? (Please check only one)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Two or More Races

### Ethnicity

Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

### Race

American Indian or Alaskan Native (Not Hispanic or Latino) - A person having origins in any of the original peoples of North America and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian (Not Hispanic or Latino) - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American (Not Hispanic or Latino) - A person having origins in any of the Black racial groups of Africa.

Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino) - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White (Not Hispanic or Latino) - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Two or More Races (not Hispanic or Latino) - All persons who identify with more than one of the above five races.

**Pre-Offer Protected Veteran Self-Identification Form**  
**[41 C.F.R. § 60-300.42]**

The Health Plan of West Virginia, Inc. is a Government contractor 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: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

1. A "disabled veteran" is one of the following:
  - a. A veteran of the U.S. military, ground, naval or air force 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
  - b. A person who was discharged or released from active duty because of a service-connected disability.
2. 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.
3. 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.
4. 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 are a member of 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 to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA. Your decision to provide the relevant information is purely voluntary on your part, and refusal to provide such information will not subject you to any adverse treatment. The information will not be used in a manner inconsistent with VEVRAA, as amended.

The information will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

- I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS OF PROTECTED VETERAN STATUS LISTED ABOVE
- I AM NOT A PROTECTED VETERAN
- I DECLINE TO SELF IDENTIFY CONCERNING VETERAN STATUS

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
Date





Company: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**Authorization:** I hereby authorize you to supply The Health Plan with the requested information.

Thank You. \_\_\_\_\_ Date: \_\_\_\_\_

Applicant's Signature

\_\_\_\_\_, Applicant, has applied to us for employment as a(n) \_\_\_\_\_. The applicant indicates dates of employment with you from \_\_\_\_\_ to \_\_\_\_\_ as a(n) \_\_\_\_\_. This information will be held in the strictest confidence. Thank you for your cooperation.

Human Resource Manager

### Reference Information

Period of employment: \_\_\_\_\_ to \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Eligible for Rehire?  Yes  No

If No, why not? \_\_\_\_\_

Please rate each item below:

Item	Excellent	Good	Fair	Poor
Careful, conscientious worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Volume of work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initiative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attitude toward work and company	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance / Promptness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Comments:

\_\_\_\_\_

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

Position: \_\_\_\_\_