

**EMPLOYMENT APPLICATION**  
**ELKHART COUNTY**  
**Personnel and Insurance**  
**117 North Second Street, Room 113**  
**Goshen, IN 46526-3231**  
**Phone: (574) 535-6725 Fax: (574) 535-6750**

**INSTRUCTIONS:**

Print in ink or use typewriter. Every question must be answered. If question does not apply to you, so state with N/A. If space is not sufficient, attach separate sheet. **DO NOT MISSTATE OR OMIT** facts since the statements made herein are subject to verification to determine your qualifications for employment. Fill out completely and sign. Incomplete applications will be discarded.

Elkhart County is an Equal Employment Opportunity Employer.

Last Name	First Name	Middle Name	Date of Application
Present Address			Telephone Number
City	State	Zip Code	Alternate Telephone Number
Positions(s) Applying For:			Social Security Number
Availability for Employment: Do you want to work — <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			Hours and Day Available
If hired, how soon could you begin work?			Minimum Salary Acceptable

**Note:** If you wish to attach a resume or vita you may do so – however, please answer all inquires your resume does not cover and sign the application form. When your resume covers the required information indicate this with “See Resume”.

**EDUCATION:**

A. List all high schools and universities attended. If requested, attach transcripts. List other schools or training (trade, vocational, business, or military).

NAME	LOCATION	YEARS ATTENDED	DATE OF GRADUATION	COURSES/TYPE	DEGREE

B. Give a brief description of your major course of study.

# EMPLOYMENT HISTORY

Begin with your current or most recent job.

Name and Address of Employer	From Date	Position Held	Reason For Leaving
	To Date	Supervisor's Name & Title	
			Ending Salary

Describe in Detail the Work You Did

Name and Address of Employer	From Date	Position Held	Reason For Leaving
	To Date	Supervisor's Name & Title	
			Ending Salary

Name and Address of Employer	From Date	Position Held	Reason For Leaving
	To Date	Supervisor's Name & Title	
			Ending Salary

Name and Address of Employer	From Date	Position Held	Reason For Leaving
	To Date	Supervisor's Name & Title	
			Ending Salary

Were you ever Discharged or Forced to Resign from any position?  Yes  No

If Yes, why?

May we refer to your Previous Employers?  Yes  No If No, Which Employer and why?

May we Refer to your Present Employer?  Yes  No

Have you previously worked for Elkhart County?  Yes  No If so, what department? \_\_\_\_\_

Reason for leaving:



**COMPLETE ONLY IF JOB APPLYING FOR INVOLVES DRIVING**

If you are applying for a position that requires operation of a motor vehicle, please complete the following section:

Give the following information concerning any operator's license that you have held or now hold.

Type of License	Placed Issued	Expiration Date	Restrictions

Give Name and Address of the Insurance Company with whom you now have automobile insurance.

- Within the last five (5) years have you –
- been denied issuance of a license?  Yes  No
  - had a license suspended or revoked?  Yes  No
  - been denied automobile insurance?  Yes  No
  - has insurance withdrawn or revoked?  Yes  No

If the answer to any of the above questions is "Yes", explain in full:

**Please read the following paragraphs before signing below.**

By signature below I acknowledge receipt of the "Notice to Applicants for Elkhart County Employment – Group Health Plan."

A false answer to any question in this application may be grounds for not employing you, or for dismissing you after you begin work. All the information you give will be considered in reviewing your application and is subject to investigation.

"I certify that all the statements made in this application are true, complete and correct to the best of my knowledge and belief, and are made in good faith. I authorize my previous employers, schools or persons named to give Elkhart County any information regarding my employment or educational background. I grant my permission for any investigation of the information I have provided in this application. I further understand the information is job-related and non-discriminatory."

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

**DO NOT WRITE BELOW THIS LINE.**

Interviewer's Comments

Eligible for Hire \_\_\_\_\_

Not Eligible for Hire \_\_\_\_\_

Reason for Ineligibility \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# ELKHART COUNTY EEO DATA SHEET

The Federal Government requires the following information be collected in order to for us to demonstrate compliance with Equal Employment Opportunity and Affirmative Action. This data sheet will be detached from your Application for Employment by the Personnel Department and will in no way be used to make employment decisions or for other employment purposes.

We do appreciate your providing us with this information and thank you for assisting us in our data collection efforts.

## **PERSONAL DATA**

Name: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Position Applied For/Department: \_\_\_\_\_

## **REFERRAL SOURCE Where did you hear about the job opening you are applying for? Please check one.**

- |  |   |
|--|---|
| <input type="checkbox"/> Job Vacancy Notice        | <input type="checkbox"/> Goshen News                                  |
| <input type="checkbox"/> County Website            | <input type="checkbox"/> Elkhart Truth                                |
| <input type="checkbox"/> Internet Job Posting      | <input type="checkbox"/> Other Newspaper (specify)<br>_____           |
| <input type="checkbox"/> County Department         |   |
| <input type="checkbox"/> County Employee           | <input type="checkbox"/> Private Employment Agency (specify)<br>_____ |
| <input type="checkbox"/> Family Member/Friend      |   |
| <input type="checkbox"/> Call-in/Answering Machine | <input type="checkbox"/> Community Agency (specify)<br>_____          |
| <input type="checkbox"/> Television Advertisement  |   |
| <input type="checkbox"/> Workforce Development     | <input type="checkbox"/> Other - Not listed above (specify)<br>_____  |

## **ETHNIC GROUP Please check one.**

- |  |   |
|--|---|
| <input type="checkbox"/> White                             | <input type="checkbox"/> Black                  |
| <input type="checkbox"/> Hispanic                          | <input type="checkbox"/> Asian/Pacific Islander |
| <input type="checkbox"/> American Indian or Alaskan Native |   |

## **VETERANS STATUS Are you a veteran of any branch of the U.S. Armed Forces?**

- Yes       No      If yes, Branch \_\_\_\_\_

**ELKHART COUNTY, INDIANA**  
**Employee HIPAA Opt Out Notification**  
**2010**

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Elkhart County, Indiana has elected to exempt from the following requirements:

Elkhart County, Indiana is eligible to opt out of certain provisions of the Health Insurance Portability and Accountability Act, and has elected to do so, as detailed below:

1. Limitations on preexisting condition exclusion periods. A preexisting condition exclusion period generally may not exceed 12 months, and generally must be reduced by prior health coverage an individual has had. Also, a plan may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition, nor, under certain conditions, with respect to newborns or children adopted or placed for adoption.

*The pre-existing limitation period for Elkhart County will continue to be 6 months for an employee (or 3 months treatment free) and 12 months for a dependent.*

3. Prohibitions against discriminating against individual participants and beneficiaries based on health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

*If you do not apply for coverage when eligible, you will be required to provide evidence of insurability to be accepted for coverage. Based on the information you provide, you may be declined for coverage.*

5. Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

7. Coverage of dependent students on medically necessary leave of absence. Group health plans are required to continue coverage for up to one year for a dependent child, covered as a dependent under the plan based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these Federal requirements will be in effect for the 2010-2011 plan year beginning February 1, 2010 through January 31, 2011. The election may be renewed for subsequent plan years.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a pre-existing condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.