



Managed Care Resources
1516 Westwood Blvd., Ste 201
Los Angeles, Ca 90024
Phone: 310-470-4232 or 800-350-1471
Fax: 310-475-4737
www.mcr4jobs.com

Independent Contractor Application Packet

Please complete and return packet ASAP. If packet is not received it may delay your start date. Thank you for your cooperation.



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PROFESSIONAL DATA AND SKILLS INVENTORY

Interview Date: In Person Telephone
Name: Social Security#:
Home Address: City: State/Zip:
Home Phone: Mobile: Email:
Currently Employed? No Yes Where:
Position: Work Phone:
Work Desired: Temporary Temp to Hire Permanent
Salary Desired: Temp: /HR Permanent: /HR /Annual
Other Agencies where you are registered:
Prof License # Expiration Date:
In Emergency Call (Include Relationship & Phone #)

SETTINGS YOU HAVE WORKED IN:

Home Health Clinical UM OPO Clinical UR TPA TCU
Hospital Clinical UM Psych/CD Clinical UR HMO IPA
Long Term Care Clinical UR Rehabilitation Hospital/Unit PPO MD Office
Medical Group Medical Management Co. Managed Care Co.
Other:

LICENSED AS:

ART LVN RN RRA MSW BSW Other

LOCATIONS YOU ARE WILLING TO WORK:

Apple Valley Chino Fullerton Inland Empire San Gab Valley Whittier
Kern County LA West LA Long Beach Santa Barbara Ventura
Orange Cnty Palmdale Pasadena Palm Springs Simi Valley So. Bay
Riverside San Bern. San Diego San Fern Valley San Luis Obispo Covina
Thousand Oaks Other

Northern Cal:

Castro Valley Concord Fresno Hayward Oakland/Alameda S F Bay San Jose
Marin County Modesto Monterey Redding Sacramento San Mateo Vallejo
Daly City Stockton Santa Cruz Merced Other

This is a data entry form so that we can match your skills to jobs. It is important that you complete it accurately and thoroughly. Please ask your interviewer if you need any clarification.

Auditing

- Bill Audit (Defense)
- Bill Audit (Insurance)
- Bill Review (Insurance)
- Other _____

Certification

- CPHQ CPUR
- CCM CDMS
- CPR PHN
- HHN Other _____

Case Management

- Case Mgmt (Home Health)
- Case Mgmt (Hospital)
- Case Mgmt (Insurance)
- Case Mgmt (Workers Comp)
- Other _____

Criteria/Codes

- CPT DRG's
- HEDIS ICD-9
- IHQ InterQual (SI/IS)
- SIMS LOS
- M&R Other _____

Computers

- Apple/Compatible
- IBM PC/Compatible
- Main Frame Only

Consulting

- Consulting CM
- Consulting JCAHO Prep
- Consulting NCQA Prep
- Consulting QM
- Consulting RM
- Consulting UM
- Consulting Other _____

Education

- AA BS/BA
- BS HLT/ADM PHD
- BSN MA/MS
- JD MBA
- MHA MSN
- Other _____

Experience

- Critical Care
- Infection Control
- Med/Surg
- Neonatal Ob/GYN
- Oncology Orthopedics
- Pediatrics Rehabilitation
- Surgery
- Other Exper: _____

Financial Class

- MediCare HCFA 485
- MediCade TARS
- Workers Comp

Languages (Other than English)

- Specify: _____

Management

- Administration
- Supervision
- Other _____

QM

- QM Chart Audits
- QM Data Analysis
- QM Data Display
- QM Data Extraction
- QM DHS Audit Tool
- QM Grievance & Appeals
- QM Home Health
- QM Hospital Depts
- QM JC Accreditation
- QM IPA
- QM Med Staff HMO/INS

- QM NCQA Audit Tool
- QM NIPAC Audit Tool
- QM Nursing (Hospital)
- QM Med Staff Hospital
- QM Report Prep & Present
- Other QM _____

Utilization Mgmt.

- Authorizations (IPA)
- Disability Review
- Discharge planning
- Pre-Adm. Certification
- UM Concurrent
- UM Onsite
- UM Telephonic
- UM Workers Comp
- Other _____

Health Status

- Physical Date _____
- PPD Date _____
- CXR Date _____

Miscellaneous

- Birth Month _____
- Available for out of State Assignments
- Have a Car
- Type WPM _____

How did you hear of MCR?

- Advert Where? _____
- CareerBuilder
- Company Website
- Nurse Week
- MCA/MCR Nurse _____
- Employer
- Friend
- Other _____

Former Employers

List last 4 employers, starting with the most recent. Please complete this entire form. Please DO NOT write "See Resume". Do not forget to indicate whether or not we can contact former supervisor.

Name of Present or Last Employer: _____			
Address: _____			
Job Title: _____	Phone: _____		
Start Date: _____	Starting Salary: _____	Leaving Date: _____	Final Salary: _____
Exact Reason(s) for Leaving: _____			
Name/Title of Immediate Supervisor: _____	May We Contact? _____		

Name of Former Employer: _____			
Address: _____			
Job Title: _____	Phone: _____		
Start Date: _____	Starting Salary: _____	Leaving Date: _____	Final Salary: _____
Exact Reason(s) for Leaving: _____			
Name/Title of Immediate Supervisor: _____	May We Contact? _____		

Name of Former Employer: _____			
Address: _____			
Job Title: _____	Phone: _____		
Start Date: _____	Starting Salary: _____	Leaving Date: _____	Final Salary: _____
Exact Reason(s) for Leaving: _____			
Name/Title of Immediate Supervisor: _____	May We Contact? _____		

Name of Former Employer: _____			
Address: _____			
Job Title: _____	Phone: _____		
Start Date: _____	Starting Salary: _____	Leaving Date: _____	Final Salary: _____
Exact Reason(s) for Leaving: _____			
Name/Title of Immediate Supervisor: _____	May We Contact? _____		

IF YOU HAVE WORKED AS A TEMP BEFORE: List Facilities to which would like to return.

1. _____ 2. _____
3. _____ 4. _____

I confirm that the information that I have given on his form is true and accurate.

Signed: _____ Date: _____

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DIRECT DEPOSIT AUTHORIZATION AND REQUEST

IC Name _____ Date _____
(PLEASE PRINT)

SSN # _____

_____ A new account

_____ A new account to replace an existing direct deposit account

- Account number you are replacing (REQUIRED) _____

_____ Canceling Direct Deposit

- We must cancel direct deposit BEFORE you close an account

_____ DECLINING DIRECT DEPOSIT

- You may sign up for Direct Deposit at any time in the future

Name of Bank _____

Bank Account Number _____

Bank Transit Routing Number _____
(Contact your bank for this information)

_____ Checking Account
(Include a voided check)

_____ **Savings Account**
(Verify the Routing Number with your Bank, as the number on your deposit slip **MAY NOT** be correct)

I authorize Managed Care Resources and the bank listed above to deposit payment of my invoice, as indicated, to my account. I have included a copy of a voided check and I have verified my bank transit routing number.

Signature _____ Date _____

Note: The authorization process for direct deposit may take up to two weeks.



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REFERENCE RELEASE FORM

APPLICANT _____
Last First MI Maiden

SOCIAL SECURITY # _____ - _____ - _____

I hereby release from all liability the company or person giving a reference, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of Managed Care Resources and other requesting third parties on a need to know basis. I also release Managed Care Resources from all liability for any damages from the disclosure of this information.

APPLICANT SIGNATURE

DATE

Employee/Patient Confidentiality Agreement

Independent Contractors furnishing services to Managed Care Resources' clients and employees working through Making Careers are bound under the Federal Law known as HIPPA. The following is intended to inform you of the importance of maintaining employee and patient confidentiality, the implication of computer data access and the importance of confidentially associated with such access.

HIPAA – Protected Health Information (PHI)

HIPAA defines PHI to include any information, whether in electronic, printed or spoken form that identifies or could be used to identify an individual and relates to either the past, present, or future health or condition (physical or mental), the provision of health care; or the past, present, or future payment for the provision of healthcare. Such information is PHI if it is created or received either by a covered entity or by an employer. Information about the provisions of HIPAA is posted on our website at www.mcr4jobs.com and all associates are required to read this material. If you do not have access to our website, please contact us on 310-470-4232 and request a printed copy of the material.

Confidentiality of Medical Information Act (CMIA – California Civil Code 56. et. seq.)

The use and disclosure of medical information by employers is governed by portions of the CMIA. The CMIA protects medical information, individually identifiable information in electronic or physical form in the possession of or derived from provider of health care, which the employer possesses and which pertains to one of its employees. Then Company may disclose an employee's medical information without authorization for purposes of administering and maintain benefit plans and determine eligibility for leave from work for medical reasons or if compelled by judicial or administrative process or by any other specific provision of law.

In consideration and as a condition of my continued relationship with Managed Care Resources or employment with Making Careers, it's successors in business, or assignments (the "Company"); I hereby acknowledge, understand and agree:

1. By reason of any duties or in the course of my relationship or employment I may receive or have access to verbal, written or electronic medical information concerning employees and/or their family members. I will not disclose (verbally, in written form or by electronic means) to any unauthorized person, or permit any such person to examine or make copies of any reports or other documents prepared by me, coming into my possession or control, or to which I have access, nor any other information concerning employees or family members at any time during or after my employment.
2. If and when my relationship or employment with the Company is terminated, I will not use, disclose, retain, or copy any reports or other documents prepared by me, coming into my possession or control, or to which I have access, nor any other information concerning employees and or their family members.
3. I will not use such information for my own advantages or purposes.
4. I will adhere to Company and Privacy Officer procedures governing the proper handling or disposal of printed material containing individually identifiable information
5. I will notify the Company's Privacy Officer immediately, but not later than within one business day, of any actual or suspected wrongful disclosure of employee/patient protected information, whether by me or anyone else, whether intentional or accidental.
6. I understand that the unauthorized disclosure of protected information by me may violate state and/or federal laws and subjects me to civil damages and criminal prosecution, and may subject me to disciplinary action up to and including termination or severance of relationship.

7. I understand that every provision of this Agreement shall be construed, to the extent possible, so as to be valid and enforceable. If any provision is held by a court of competent jurisdiction to be invalid, illegal, or otherwise unenforceable, such provision shall be deemed severed from this Agreement, and all other provisions shall remain in full force and effect.
8. I understand that this agreement does not constitute a contract or guarantee of employment by the Company.
9. This signed document may be placed in and become a part of my permanent personnel record and on file with the Company's Privacy Office.
10. Managed Care Resources and Making Careers have provided me with educational material relating to HIPAA requirements and I acknowledge that I have read and understand these materials and will comply with these requirements.

I ACKNOWLEDGE that I have read the foregoing Employee/Patient Confidentiality Agreement, understand it, and will be bound by it. I further acknowledge that I have read the information on HIPAA as directed above and understand its provisions.

Signature

Date

Print Name

Witness

Date

Privacy Officer

Date



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Legal Relationship Between MCR and INDEPENDENT CONTRACTOR

It is understood that all persons furnishing services to MCR clients are independent contractors with clients and are not employees or agents of MCR. It is further understood and agreed that SDI, Social Security Taxes and Income Taxes are not withheld from your pay; therefore, you are responsible for the filing of all income tax returns. I also understand that MCR files a 1099 with the U.S. Internal Revenue Service indicating your status as an independent contractor, and the you are responsible for withholding and filing your own taxes.

Signed: _____ Date: _____

For MCR: _____ Date: _____

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RELEASE AND AUTHORIZATION FORM

In accordance with my right to privacy, I have been advised by Managed Care Resources that the information described below is required to assist the same in making an employment advancement determination concerning me and that execution of this form is voluntary.

I hereby authorize any qualified agent bearing this document or a copy thereof, to obtain information from all personnel, educational institutions, government agencies, to include The Department of Justice and The Youth Authority, companies, corporations, worker's compensation information, law enforcement agencies or individuals relating to my past activities, to supply any and all information concerning my background, and release same from any liability resulting from providing such information. The information received may include, but is not limited to academic, job performance, attendance, personal history, financial record history, disciplinary, driving (DMV or MVR) records, and criminal or civil records.

I understand that the information released is for consideration of my employment application, resume and possibly for the purpose of determining my qualifications for future assignment.

I further herby release any individual associated with the compilation of such information to include record custodians, directors, officer, agent, employees, if authorized representatives of the same, from any and all liability for damages of whatever kind of nature, which may at any time accrue to me on account of (1) reliance by such person on the information submitted in my employment application; (2) reliance by such persons on the information obtained pursuant to this authorization; (3) compliance with, or any attempt to comply with, this authorization; and (4) termination of my employment based on information obtained after commencement thereof pursuant to validity of this authorization. If adverse action is taken based in whole or in part on the consumer report, we will provide to you a copy of the consumer report and a summary of the consumer's rights as prescribed by the FCRA. This report will not be used in violation of any federal or state laws and/or equal employment opportunity laws or regulations.

I herby certify that all the statements and answers set forth on this application form and documents signed are true and complete to the best of my knowledge, and I understand that if, subsequent to employment any of such statements and/or answers are found false or that information has been omitted, such false statements or omissions will be just cause for termination of my employment.

I understand that I have a right to receive a copy of any consumer report created as a result of this release form, by Liberty Alliance Inc., I have also stated clearly in the boxes listed below as to my desire to receive that report from, this company to which I am applying upon its completion. The investigative consumer-reporting agency preparing the report(s) is Liberty Alliance, Inc., 22707 La Palma Ave., Yorba Linda, CA 92887, telephone (714) 696-5410. Their files are available for review by appointment, by certified mail or telephonically with proper identification.

PLEASE PRINT CLEARLY

SIGNATURE OF APPLICANT

PRINT FULL NAME (First, Middle & Last Name)

DATE

APPLICANT'S ADDRESS

For purposes of gathering this information, I agree to supply the following information which may be required by law enforcement agencies and other entities for positive identification purposes in checking records. It is confidential and will not be used for any other purpose.

DATE OF BIRTH

DRIVER'S LICENSE NUMBER

STATE

SOCIAL SECURITY NUMBER

LAST NAME AS IT APPEARS ON LICENSE

(PLEASE PRINT CLEARLY)

Yes, I would like a copy of any investigative consumer report that is conducted by Liberty Alliance, Inc.

No, I do not need a copy of any investigative consumer report that is conducted by liberty Alliance, Inc.

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Administrative Policies

It is the policy of Managed Care Resources (MCR) that Independent Contractors:

1. Notify MCR of any changes that may/will affect our working relationship. These changes include, but are not exclusive to:

- Changes to your status: Married, Divorced, etc.
- Changes to your Legal name
- Changes in Emergency Contact Information
- Changes in Contact Information
 - Telephone Number
 - Mobile Phone Number
 - Fax Number
 - Email Address
 - Home/Mailing Address
 - Direct Extension at Worksite

2. Notify both your Worksite Supervisor and your Recruiter **BEFORE** taking vacations. You are required to notify your Recruiter of any planned vacations **BEFORE** taking an assignment.

***PLEASE NOTE:** Any Contractors who takes an assignment with MCR is expected to complete the assignment without breaks or pauses unless there are extenuating circumstances. If you feel that you will be unable to complete an offered assignment, let your recruiter know **BEFORE** you accept the assignment, we will confer with our client at the worksite to determine if the arrangements are acceptable to the client.*

3. Notify your Worksite Supervisor and your Recruiter if you will be absent from work due to illness. You are required to contact both your Worksite Supervisor and your Recruiter before your work day begins.

For example, if you are scheduled to work from 8am to 5pm but you are ill, you are required to call both your Worksite Supervisor and your Recruiter no later than 7:30am to notify them that you will be unable to attend work. You may be required to present a doctor's note stating that you are able to return to work.

4. Notify your Worksite Supervisor and your Recruiter if you will be away from your assignment for personal reasons. If this is a scheduled appointment, the Worksite Supervisor and Managed Care Resources should be notified as soon as the appointment is made. In all cases of absence from an assignment, you should give as much notice as is possible to both the Worksite and Managed Care Resources. We suggest that you schedule your appointments before or after work or on weekends, if possible.

After you have read the above, please sign below and return this form to Managed Care Resources along with your Application Packet. Your signature indicates your compliance to the above policies. Thank you for your cooperation.

Signature

Print Name

Date