



WASHINGTON STATE
Department of Social
& Health Services

ADSA Aging & Disability
Services Administration

Liberty Shores BH 1834
Name and License Number of Educating Facility

PRESENTS THIS CERTIFICATE TO

ASHLEY REDICAR

for successfully completing the 28 hour basic training *

Revised Fundamentals of Caregiving

Second Edition

Course Name

Arena Simlin

Signature of Instructor

9/30/10
Date

Food safety test passed	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Signature of Instructor	Arena Simlin	

* See back of certificate for course content.

(revised 7/05)



Washington State
Department of Social
& Health Services

ADSA Aging & Disability
Services Administration

CERTIFICATE OF COMPLETION

Liberty Shores BH 834
Name and License Number of Educating Facility

Ashley Redican

Has successfully completed

Caregiver Mental Health Specialty Training

Alena Gimlin
Instructor Name Printed

Alena Gimlin 9/27/10
Instructor Signature Date

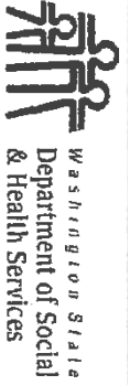
Poubo, WA 9/27/10
Class Location Class Month/Year

4 hours
Total Class Hours (not including testing time)

Total class hours are equivalent to CE credit

(7/04)

✓



ADDA Aging & Disability Services Administration

Blue Step

Liberty Shores BH 1834
Name and License Number of Educating Facility

CERTIFICATE OF COMPLETION

Ashtley Redicum
Has successfully completed

Caregiver Dementia Specialty Training

10 hours
Total Class Hours (not including testing time)

Testing completed and passed

Yes No

Arena Gimlin 12/15/10
Instructor Signature Date

Arena Gimlin
Instructor Name Printed

Arena Gimlin 12/15/10
Instructor Signature Date

Liberty Shores 12/10
Class Location Class Month/Year

Total class hours are equivalent to CE credit

(6/07)



Character, Competence, and Suitability (CCS) Determination for Unsupervised Access to Minors and Vulnerable Adults HCS / AAA / DDA

A CCS determination is a review process that the Department or its designee uses to decide whether an individual may have unsupervised access to minors and vulnerable adults. The decision is based on a review of available information about the individual. This form may **NOT** be used when the individual has automatically disqualifying: convictions, pending charges (WAC 388-113-020) or negative actions (ABC Result Letter).

Section 1. Demographic Information			
INDIVIDUAL'S NAME <i>Ashley Redican</i>	DATE OF BIRTH <i>10/31/91</i>	CLIENT'S NAME (HCS / AAA ONLY)	
REVIEWER'S NAME <i>Alena Gimlin</i>	REVIEWER'S TITLE <i>Executive Director</i>	DATE OF REVIEW <i>4-14-17</i>	
OFFICE NAME			
<input checked="" type="checkbox"/> New Review <input type="checkbox"/> Renewal.* Last CCS is still applicable. (see instructions)			

Section 2. Information to review for determination (additional space available on back of form)				
List all non-disqualifying: • Convictions • Pending Charges • Negative Actions • Other	Date	Sentencing or Incarceration Information	Number of years since conviction, charge, negative action, or other issue	Comments or other factors (see instructions)
Example: Theft 3	<i>01/15/1984</i>	<i>Jail</i>	<i>30</i>	<i>3-year disqualification. IP has had no other convictions in the last 30 years.</i>
<i>Theft 3</i>	<i>03/01/2014</i>	<i>fine</i>	<i>3+</i>	<i>same day for both crime, no other record employee has done community service, paid fine.</i>
<i>Assault 34</i>	<i>03/04/2014</i>	<i>fine</i>	<i>3+</i>	

Section 3. Factors to consider when making a determination include, but are not limited to, the following:

- Whether you have a reasonable, good faith belief that he or she would be unable to meet the care needs of the client.
 - e.g., if he or she would be responsible for driving the client, and has multiple DUIs.
- Vulnerability of the client under his or her care.
- Behaviors since the conviction(s), negative action(s) or other adverse behavior(s).
- Pattern of offenses or other behaviors that may put the client at risk.
 - e.g., if he or she would be working for a client with dementia, and has recent theft convictions.
- Number of years since the conviction(s), negative action(s), or other issue(s).
- Whether he or she self-disclosed the conviction(s), pending charge(s) and/or negative action(s).
- Other health and safety concerns.

Section 4. Results of CCS determination

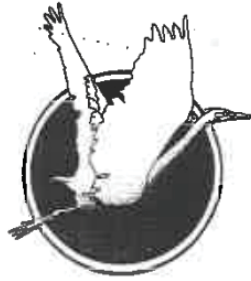
After careful review of the information above, the department or designee has determined that the individual (check one):

A. May have unsupervised access to minors or vulnerable adults; or
Comments:

B. May not have unsupervised access to minors or vulnerable adults.
Comments:

C. Does not have the character, competence or suitability to work with the client named in Section 1 above.
(HCS / AAA only)
Comments:

Signature of Reviewer: *Alena Gimlin* *4/14/17*



12 December 2011

Subject: Exempt Long Term Care Worker

The following employee is exempt from the requirements of certified long-term care worker:

Name of Employee: Ashley Redican
Date of Hire: 4/9/09
First Day Worked: 9/10/10 moved to Nursing Dept
Last Day Worked: Still employed
Date of Birth: 10/31/91
Job Description: Caregiver
Specialty Training: Dementia 12-15-10
mental Health 9-27-10
Revised Fundamentals 9-30-10

Licensure:

Sigrid Howard/NHA
Administrator
Liberty Shores/Harbor House

Alena Gimlin
Director of Staff Development
Liberty Shores/Harbor House



Background Check Authorization

New Hire

faxed 4/12/17
00

PROCESSING CODE

SECTION 1. ENTITY INFORMATION (COMPLETED BY DSHS STAFF, PROVIDER, APPLICANT, LICENSEE, AND/OR CONTRACTOR)

1A. ENTITY REQUESTING THE BACKGROUND CHECK
The Ridge

1B. ENTIRE ADDRESS OF ENTITY LISTED IN BOX 1A
**1501 Tower View Circle N.W.
Silverdale, Wa. 98383**

1C. NAME OF SECONDARY ENTITY

2. REQUIRED: NAME AND SIGNATURE OF PERSON REQUESTING THE BACKGROUND CHECK

PRINTED NAME: **Alena Gimlin** SIGNATURE: *Alena Gimlin*

3. REQUIRED ONLY FOR DSHS STATE EMPLOYMENT

DSHS POSITION NUMBER _____ (WRITE NONE IF NONE) DSHS JOB CLASSIFICATION: _____ PERSONNEL IDENTIFICATION NUMBER: _____

Permanent appointment Non-permanent appointment Work study / student internship Volunteer Acting

4. REQUIRED: BCCU ACCOUNT NUMBER
BH2231 *Fingerprints*

5. DSHS ID NUMBER OR NAME
NONE

APPLICANT INFORMATION ONLY (THE PERSON TO BE CHECKED IS THE APPLICANT)

7. REQUIRED: DATE OF BIRTH (MM/DD/YYYY)
10/31/1991

8. PRINT YOUR E-MAIL ADDRESS
ashleyrenee@protonmail.com

9. REQUIRED: PRINT YOUR NAME AS IT IS LISTED ON YOUR DRIVER'S LICENSE OR OTHER PHOTO ID. WRITE N/A IN THE BOX IF YOU DON'T HAVE A NAME TO ENTER.

FIRST: **Ashley** MIDDLE: **Benee** LAST: **Redican**

10. REQUIRED: PRINT ALL OTHER FIRST, MIDDLE AND LAST NAMES YOU HAVE USED. WRITE N/A IN THE BOX IF YOU DON'T HAVE A NAME TO ENTER.

FIRST: **N/A** MIDDLE: **N/A** LAST: **N/A**

REQUIRED: SELF DISCLOSURE QUESTIONS. SEE INSTRUCTIONS.

You must answer Questions 11A through 14. Attach an additional sheet of paper if you need to list additional crimes or pending charges.

11A. Have you been convicted of any crime? If yes, fill in the blanks below. Yes No
Assault (4) Theft (3) Degree: **4/3** State: **WA** Conviction date: **3/5/2014**

11B. Do you have charges (pending) against you for any crime? If yes, fill in the blanks below. Yes No
NO Degree: _____ State: _____

12. Has a court or state agency ever issued you an order or other final notification stating that you have sexually abused, physically abused, neglected, abandoned, or exploited a child, juvenile, or vulnerable adult? Yes No

13. Has a government agency ever denied, terminated, or revoked your contract or license for failing to care for children, juveniles, or vulnerable adults; or have you ever given up your contract or license because a government agency was taking action against you for failing to care for children, juveniles, or vulnerable adults? Yes No

1. Has a court ever entered any of the following against you for abuse, sexual abuse, neglect, abandonment, domestic violence, exploitation, or financial exploitation of a vulnerable adult, juvenile or child? Yes No

- Permanent* vulnerable adult protection order / restraining order, either active or expired, under RCW 74.34.
- Sexual assault protection order under RCW 7.90.
- Permanent* civil anti-harassment protection order, either active or expired, under RCW 10.14.

See instructions for description of "permanent."

15. REQUIRED: PRINT YOUR DRIVER'S LICENSE OR STATE IDENTIFICATION NUMBER (WRITE NONE IF NONE) REQUIRED: PRINT THE NAME OF THE STATE ON YOUR LICENSE OR ID
BEDICAR09LPU **Ashley Redican**

16. REQUIRED: Have you lived in any state or country other than Washington State within the last three years (36 months)? Yes No

17. A. REQUIRED: PRINT YOUR MAILING ADDRESS WHERE WE CAN SEND YOU CONFIDENTIAL INFORMATION
Hilde Lee's dr. NE APT. NO. _____ CITY **Poulsbo** STATE **WA** ZIP CODE **98370**

B. REQUIRED: PRINT THE STREET ADDRESS WHERE YOU LIVE NOW (WRITE "SAME" IF YOUR STREET ADDRESS IS THE SAME AS YOUR MAILING ADDRESS)
same APT. NO. _____ CITY _____ STATE _____ ZIP CODE _____

C. REQUIRED: GIVE THE DAYTIME AREA CODE AND TELEPHONE NUMBER WHERE YOU CAN BE REACHED
360 328 8087

18. I am the person named above. If I do not tell the whole truth on this form, I understand I can be charged with perjury and I may not be allowed to work with vulnerable adults, juveniles or children. I understand and agree my signature in box number 19 means:

- I give DSHS permission to check my background with any governmental entity and law enforcement agency.
- My background check result may include prior self-disclosure information and fingerprint results that are contained in the DSHS Background Check System and that this information will be reported as allowed by federal or state law.
- If a final finding is identified, DSHS will report only my name and that a final finding was identified on the background check result.
- DSHS will give my background check result to the persons or entities named in Section 1 and may release my background check results to other persons or entities when the law authorizes or requires DSHS to do so. Fingerprint rap sheets are provided if allowed by federal or state law.
- The entity requesting this background check must submit this form to the Background Check Central Unit within the timeframe required by the DSHS oversight program.

19. REQUIRED: YOUR SIGNATURE. YOUR PARENT OR GUARDIAN'S SIGNATURE IF YOU ARE UNDER 18. SIGNATURE: *Ashley Redican*

20. REQUIRED: TODAY'S DATE (MM/DD/YYYY) **4/12/17**

PROGRAM USE - FOLLOW INSTRUCTIONS PROVIDED BY YOUR DSHS OVERSIGHT PROGRAM

 KITSAP PUBLIC HEALTH DISTRICT Washington State Food Worker Card	
(signature) ASHLEY REDICAN	
 Health Officer <small>Kitsap County Health District</small>	Valid from 05/19/2017 to 05/19/2019
1191905ACRAJ2AR1	
	

===== TRANSACTION RECORD =====
TPC ONLINE FOOD CARDS
3629 S D ST MAILSTOP 006
TACOMA, WA 98418
United States
WWW.TPCHD.ORG

TYPE: Purchase

ACCT: Visa \$ 10.00 USD

CARDHOLDER NAME : Alena Gimlin
CARD NUMBER : #####5306
DATE/TIME : May 19, 2017 17:05:16
REFERENCE # : 001 0446170 M
AUTHOR. # : 068737
TRANS. REF. : 2169446

Approved - Thank You

Please retain this copy for your records.

Cardholder will pay above amount to
card issuer pursuant to cardholder
agreement.



Personnel Change Notice

Employee Name: Ashley Redican Facility: The Ridge
Department: Nursing Position: Caregiver

New Hire Information:

Hire Date: _____ Wage: _____ HR Appointment Date: _____ Time: _____
Status: Full Time Part Time On-Call Shift: AM PM NOC

Change Information:

Dept/Title From: _____ To: _____ Effective Date: _____
Facility From: _____ To: _____ Effective Date: _____
Wage/Salary From: _____ % To: _____ Effective Date: _____

Reason for Increase: _____

Employee Information Change:

Name Address Phone W4 Emergency Info e-Mail Effective Date: _____

Termination / Leave of Absence:

Voluntary Involuntary

Effective Date: _____ Last Day Worked: _____ Vacation Payout Approved: Yes No

Rehire: Yes No

Termination Reasons

- Abandoned Job
- Absenteeism
- Another Job (Pay & Benefits)
- Another Job (Shift)
- Did Not Pass Background Check
- Did Not Return From LOA
- Did Not State Reason
- Failing Health
- Insubordination
- Leaving For Military
- License Expired
- Multiple Warnings
- On Call - Not Available
- Poor Work Performance
- Quit Without Notice
- Relocated
- Retired
- Return To School
- Tardiness
- Walked Off Job
- Policy Violation

Leave of Absence Reasons

- Disability
- Personal
- FMLA
- Military
- Other: _____

Administrative:

Supervisor: _____ Date: _____
Executive Administrator: Alexa Simlin Date: 8/11/17

Human Resources:

Vacation Hours Available: _____ Vacation Cash Out Sent to Payroll Yes No
Terminated HRO/Paychex _____ Terminated Holiday List TLO/Paychex _____ Disable Healthcare Academy _____
Disabled in PCC _____ Disabled in QuickMAR _____ Background New/Old Check Pulled _____ I-9 Pulled/Moved _____
Personnel File Pulled _____ Confidential File Pulled _____ New Hire Check List Pulled _____
Do Not Terminate Before: _____



Personnel Change Notice

Employee Name: Ashley Redican Facility: The Ridge
Department: Nursing Position: Caregiver

New Hire Information:

Hire Date: 4/12/17 Wage: 13.50/hr HR Appointment Date: 4/12/17 Time: 2:00p
Status: Full Time Part Time On-Call Shift: AM PM NOC

Change Information:

Dept/Title From: _____ To: _____ Effective Date: _____
Facility From: _____ To: _____ Effective Date: _____
Wage/Salary From: _____ % To: _____ Effective Date: _____



Personnel Change Notice

Employee Name: Ashley Redican Facility: The Ridge
Department: Nursing Position: Caregiver

New Hire Information:

Hire Date: 4/12/17 Wage: 13.50/hr HR Appointment Date: 4/12/17 Time: 2:00p
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Change Information:

Dept/Title From: _____ To: _____ Effective Date: _____
Facility From: _____ To: _____ Effective Date: _____
Wage/Salary From: _____ % To: _____ Effective Date: _____

Reason for Increase: _____

Employee Information Change:

Name Address Phone W4 Emergency Info e-Mail Effective Date: _____

Termination / Leave of Absence:

Effective Date: _____ Last Day Worked: _____ Voluntary Involuntary
Vacation Payout Approved: Yes No

Rehire: Yes No

Termination Reasons

- | | | |
|--|--|--|
| <input type="checkbox"/> Abandoned Job | <input type="checkbox"/> Failing Health | <input type="checkbox"/> Quit Without Notice |
| <input type="checkbox"/> Absenteeism | <input type="checkbox"/> Insubordination | <input type="checkbox"/> Relocated |
| <input type="checkbox"/> Another Job (Pay & Benefits) | <input type="checkbox"/> Leaving For Military | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Another Job (Shift) | <input type="checkbox"/> License Expired | <input type="checkbox"/> Return To School |
| <input type="checkbox"/> Did Not Pass Background Check | <input type="checkbox"/> Multiple Warnings | <input type="checkbox"/> Tardiness |
| <input type="checkbox"/> Did Not Return From LOA | <input type="checkbox"/> On Call - Not Available | <input type="checkbox"/> Walked Off Job |
| <input type="checkbox"/> Did Not State Reason | <input type="checkbox"/> Poor Work Performance | <input type="checkbox"/> Policy Violation |

Leave of Absence Reasons

- Disability
- Personal
- FMLA
- Military
- Other: _____

Administrative:

Supervisor: _____ Date: _____
Executive Administrator: Valera Gimelin Date: 4/14/17

Human Resources:

Vacation Hours Available: _____ Vacation Cash Out Sent to Payroll Yes No
Terminated HRO/Paychex _____ Terminated Holiday List TLO/Paychex _____ Disable Healthcare Academy _____
Disabled in PCC _____ Disabled in QuickMAR _____ Background New/Old Check Pulled _____ I-9 Pulled/Moved _____
Personnel File Pulled _____ Confidential File Pulled _____ New Hire Check List Pulled _____
Do Not Terminate Before: _____



You'll Applaud The Quality, Service and Care Of Our Retirement, Assisted Living, & Health Care Communities.

Offer Letter

Name: Ashley Redican

You have been offered a position as a: Caregiver

Your starting wage is: 13.50/hr

Your 1st day at work is set for: 4/13/17

Other pertinent information:

I accept the position

Ashley Redican

Date

4/12/17

Welcome to Encore Communities!



For More Information About Any Quality Encore Community Please Call (360) 698-6727 or 1-800-773-1945

www.encorecommunities.com



MCM Pre-Screening Worksheet
Work Opportunity Tax Credit Eligibility Worksheet
 Mckenzie Chase Management, PO Box 30550, Seattle, WA 98113, (866) 547-8277

Note to Applicant: Answering these questions will not affect your employment or benefits. All this information will be kept confidential and will only be used to provide tax savings for your new employer.

Employer: Santé Ops **Location:** Sante - The Ridge **Estimated Start Date:** 4/13/17

Name: Ashley Redican **Social Security Number:** 5

1. Are you under the age of 40? If yes, birth date: 10/31/1991 Yes/No

2. Have you or a member of your family received Food Stamps over the last 6 months? Yes/No

If yes, please complete	Name of recipient if not yourself: _____ City and State: _____
	Start date of benefit: ___/___/___ End date of benefit: ___/___/___

3. Have you or a family member received Welfare or Family Assistance (TANF)? Yes/No

If yes, please complete	Name of recipient if not yourself: _____ City and State: _____
	Start date of benefit: ___/___/___ End date of benefit: ___/___/___

4. Were you referred to the employer by a Career Training or Vocational Rehabilitation Agency or an Employment Network under Ticket to Work? Yes/No

If yes, please complete	Counselor's Name: _____ Phone number: _____
	Date of Completion: ___/___/___ City and State: _____

5. Have you received Supplemental Security Benefit Income (SSI) within the last 90 days? Yes/No

6. Are you an ex-felon or ex-offender convicted and/or released within the past year? Yes/No

If yes, please complete	Parole/Probation officer name: _____ Phone number: _____
	Conviction date: ___/___/___ Release date: ___/___/___
	Dept of Corrections #: _____ Was this a federal conviction? ... Yes/No

7. Are you a Veteran of the U.S. Armed Forces? Yes/No

If "yes," please complete (a), (b), (c) and (d): (a) Date entered: ___/___/___ Discharged: ___/___/___

(b) Which Service? Navy___, Army___, Air Force___, US Marines___, National Guard___, Coast Guard___

(c) Are you receiving benefits due to your disabled veteran status with the Department of Veterans Affairs? Yes/No

Start date of benefit: ___/___/___ End date of benefit: ___/___/___

(d) Were you referred to the employer by the Department of Veterans Affairs? Yes/No

8. Have you been unemployed or out of work, at any time during the last 12 months? Yes/No

If "yes," please complete (a), (b), (c) and the Long-term Unemployment Affidavit (on the next page):

(a) Have you ever received state or federal Unemployment payments? Yes/No

(b) Were you unemployed, or out of work, for 4 weeks or more during the last 12 months? Yes/No

(c) Were you unemployed, or out of work, for 6 months (27 weeks) or more during the last 12 months? Yes/No

I hereby authorize the Department of Veterans Affairs, Department of Health and Human Services, Social Security Administration, National Personnel Records Center, Ticket to Work Program, the State Unemployment Insurance agency, and other Federal, state, and local government agencies to release information to the WOTC State Office and to M.C.M. to confirm my benefit eligibility status. Further, I declare that the above information is true and correct to the best of my knowledge.

Applicant Signature: Ashley Redican **Date:** 4/12/17 **New hire:** **Rehire:**

(mcm-psw-12/5/2016)

EMPLOYEE NAME: Ashley Redican DATE OF HIRE: 4/12/17
 FACILITY: The Ridge POSITION: Caregivers

NEW HIRE CHECK LIST

- Vulnerable Adult Protection ✓ Fire Safety ✓ PPE ✓ Environmental Safety ✓ Hand Hygiene ✓
- Understanding Bloodborne Pathogens ✓ Isolation Precautions: A Lesson in Infection Control ✓ Abuse Prohibition Practices ✓
- Global Harmonization ✓ Sexual Harassment ✓ HIPPA Orientation ✓
- HIV Prevention (Caregiver/Act/Diet/Hskp/Maint/Van Driver) ✓

- E-VERIFY checked
- WA State Sex Offender site checked
- General Orientation
- N/A Homecare Aide Cert. (200 days)

- Caregiver exempt if worked in 2011 & all training complete
- Fundamentals of caregiving Doc Exempt status Dementia and mental health certs
- N/A State License check (if applicable) – Lic # _____ Expiration _____

- NAR Course Completion Date _____ Must have NAC by _____
- CPR card (If applicable) 6/3/19 (within 30 days) First Aid Card (If applicable) 6/3/19 (within 30 days)

- Food Handler's Permit Expiration Date 5/19/19 (within 14 days)
- Continuing education (all caregivers) _____ (12 hours birthdate to birthdate) Due by: 4/12/17
10/31/17

- Hepatitis B Vaccination Form Accept Declined
- 1st step TB (within 72) 2nd step TB (2 weeks after 1st step) NA Quantiferon TB _____
- Neg. result on previous 1 step in past 12 mo. OR Neg. 2 step _____, Surveillance _____, X-ray _____

- References verified and in file: 1) 2) 3) Has a two step

- Safety/Disaster/Emergency Preparedness Checklist signed
- Fire Procedure signed
- Nursing Skills/Dept Safety checklist – employee to complete & return w/in one week
- Job description
- Employee Handbook/Benefits/Acknowledgement page signed/Dress Code/Smoking/Cell Phone/Fire Arms
- I-9 Form with copies of acceptable identification 1) 2)

- Direct Deposit
- Tax Credit Worksheet completed/mailed W-4 faxed to DSHS
- Background Form faxed Returned Fingerprint results returned
(All Nursing, Activities, Van Drivers required)
- Mental Health Training (90 days) Dementia Training (90 days)
- Entered in HRO TLO: Supervisor Bldg. PREVIEW: Vac/Sick

- PCC All Nursing/Therapy/Pharmacy/Dept. Supervisors
- Quickmar (all Nurses and Med Techs)

HEARTSAVER FIRST AID CPR AED

**Heartsaver®
First Aid CPR AED**



Ashley Redican

The above individual has successfully completed the objectives and skills evaluations in accordance with the curriculum of the AHA Heartsaver First Aid CPR AED Program. Optional completed modules are those NOT marked out.

Child CPR AED Infant CPR
Issue Date June 3, 2017 Recommended Renewal Date June 2019

through the modules **NOT** completed.
card contains unique security features to protect against forgery.

HEARTSAVER FIRST AID CPR AED

Training Center Name Cascade Training TC ID # WA15590
TC Info cascadetraining.com 877-277-6778

Course Location Silverdale, WA
Instructor Name Jennifer McCreary-Diphant Inst. ID # 0314023757

Holder's Signature Ashley Redican
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