PARTNERS IN CARE
CERTIFIED HOME HEALTH AIDE REFERRAL BONUS REQUEST FORM

Name of Person Making the Referral: ____

Emp. ID: ______________________________ Date: ______________________________

Position Title: ____

Email: _______________________________ Phone: ______________________________

Signature: ____________________________

Please provide all **required information** about the person you have referred

Name of Referral: ____
First name Last name

The above-named person applied for a Certified Home Health Aide position with Partners in Care for the following region:

Westchester ☐ Nassau ☐ Suffolk ☐

REFERRAL BONUS ELIGIBILITY REQUIREMENTS

- As an applicant, the new employee **must** have named you as the referral source on his/her application;
- You will receive $100 after the Certified Home Health Aide referred above completes 12 hours of work.

PLEASE SEND THIS FORM IF YOU HAVE SOMEONE TO REFER. HR WILL ISSUUE A BONUS PAYMENT ONCE HIRE STATUS AND COMPLETION OF 12 HOURS ARE CONFIRMED.

Email completed form to Roxanne Watson, HR Specialist at: roxanne.watson@vnsny.org or fax to 212-290-3184 - Attention: Roxanne Watson.

HR Use Only: Referral Employee ID________________ Date of Hire: __________________