PROVIDER APPLICATION FORM

(Please print)

NAME____

ADDRESS____

CITY___________________________ ZIP________________ COUNTY__________

HOME PHONE________________________ WORK PHONE________________________

E-MAIL ____

OTHER PERSONS LIVING IN YOUR HOME

Name: ____

Name: ____

Name: ____

Name: ____

BACKGROUND INFORMATION

Are you legally eligible to work in the U.S.? ______yes ______no

(Proof may be required.)

Have you ever been convicted of a felony? ______yes ______no

If yes, please explain____

____

____

NOTE: Please complete the enclosed CBI form.

EDUCATION

	NAME	LOCATION	DID YOU GRADUATE	DEGREE OR AREA OF STUDY
HIGH SCHOOL				
COLLEGE				
OTHER				

ARE YOU CURRENTLY CPR CERTIFIED?_____________ FIRST AID CERTIFIED?_______________

DO YOU HAVE A MEDICATION ADMINISTRATION CERTIFICATION?_____________________________

DO YOU HAVE ANY OTHER LICENSES/CERTIFICATIONS?____

EMPLOYMENT HISTORY

Please list employers and/or service agencies you have contracted with over the course of the past ten years, including present ones.

Have you ever been employed by or contracted with ABLE? ________yes ________no If Yes, please list position(s), program(s), dates, supervisor/Program Director:

EMPLOYER/SERVICE AGENCY:	
ADDRESS:	PHONE: ( )
DATES: **From____________ To____________**	SUPERVISOR:
DUTIES AND RESPONSIBILITIES:	
REASON FOR LEAVING:	
MAY WE CONTACT THIS EMPLOYER/SERVICE AGENCY FOR A REFERENCE CHECK? YES/NO If “NO”, why?	

EMPLOYER/SERVICE AGENCY:	
ADDRESS:	PHONE: ( )
DATES: From ____________ To_____________	SUPERVISOR:
DUTIES AND RESPONSIBILITIES:	
REASON FOR LEAVING:	
MAY WE CONTACT THIS EMPLOYER/SERVICE AGENCY FOR A REFERENCE CHECK? YES/NO If “NO”, why?	

REFERENCES

Please list a minimum of three professional references who would be willing to comment on your potential to serve someone with developmental disabilities. These could include employers/service agencies which you listed above. Letters of recommendation are also encouraged.

NAME:	RELATIONSHIP:
ADDRESS	PHONE: ( )
	KNOWN HOW LONG?

NAME:	RELATIONSHIP:
ADDRESS	PHONE: ( )
	KNOWN HOW LONG?

NAME:	RELATIONSHIP:
ADDRESS	PHONE: ( )
	KNOWN HOW LONG?

I authorize ABLE Residential to contact all employers (unless otherwise noted) and references listed. I authorize those employers, service agencies and references to share with ABLE Residential any information relevant to my application to become a host home provider. By signing this I authorize ABLE to contact any service agency I have worked for/contracted with in the past that supports individuals with developmental disabilities even if they are not listed on the application.

I understand that, if accepted as a subcontractor, my status as a provider will be subject to the conditions and terms required by licensing and regulatory agencies as well as ABLE Residential policy.

I authorize ABLE Residential to investigate any statement contained within this application. I understand that any misrepresentation or omission of material fact on this application form, or in the course of the application process, may prevent me from being contracted with or, if contracted, may be cause for the immediate termination of said contract.

If previously employed or contracted by ABLE Residential, I understand that my records will be made available to the ABLE Residential staff reviewing my application and that previous supervisors/contract managers may be consulted.

_______________________________________   ______________________

Signature of Applicant   Date

A Better Life Experience

(For provider reference only. Do not return to ABLE)

CHECKLIST FOR NEW HOST HOME PROVIDERS

ITEMS NEEDED FOR POTENTIAL HOST HOME PLACEMENT

_______ Copy of Driver's License
_______ Copy of Social Security Card
_______ Copy of Homeowner's Insurance Coverage
_______ Copy of Automobile Insurance
_______ Copy of Professional License Held
_______ List of Other Individuals Living in the Home and Date(s) of Birth
_______ CBI for Adults Living in the Home
_______ Vehicle Inspection
_______ HUD Inspection

NECESSARY TRAINING PRIOR TO PLACEMENT

_______ CPR
_______ First Aid
_______ Medication Administration
_______ Infection Control/Universal Precautions
_______ Abuse/Neglect and Incident Reporting
_______ Confidentiality
_______ Introduction to Developmental Disabilities
_______ Emergency Procedures
_______ Rights of Individuals Served
_______ Philosophy/Procedures for Behavior Intervention
_______ Specific Information About Consumer(s) (*behavioral, medical, forms of Communication, routines, etc.) See individual site orientation checklist. (Completed by Program Director At 1:1 Individual Site Orientation)*
_______ Signed/Notarized Contract
_______ Host Home Provider Insurance
_______ Dental/Vision Units
_______ Financial Overview

Copies of all items need to be given to ABLE prior to placement.

Colorado Bureau of Investigation
Background Check Authorization
For ABLE Residential Services

Last Name: ____

First Name: ____

Middle Name: ____

Date of Birth: _____/_____/_____

Social Security Number: ________-________-_________

Male / Female

<u>This information is used for background check purposes only.</u>

I, ________________________________, authorize ABLE to perform a Colorado Bureau of Investigation background check, and federal bureau of investigation background check if deemed necessary.

Signature: ____

Written Authorization to Request a CAPS Check

COLORADO
Adult Protective Services
CAPS Check Unit

Pursuant to §26-3.1-111, C.R.S., certain employers named in the statute are required to request a check of the Colorado Adult Protective Services (APS) data system (CAPS) prior to hiring a new employee who will be providing direct care to at-risk adults. These employers are also authorized by statute, though not required, to request a CAPS check for current employees. The CAPS check will alert the employer as to whether or not a prospective or current employee has been substantiated as a perpetrator of physical abuse, sexual abuse, caretaker neglect, and/or exploitation of an at-risk adult. More information on the CAPS check requirement can be found in Title 26, Article 3.1 of the Colorado Revised Statutes (C.R.S.) and 12 CCR 2518-01 of the Colorado Code of Regulations (CCR).

Written authorization from the applicant/employee using this form is required per APS regulations (12 CCR 2518-1). Please complete this entire form. It is recommended that you and the employer keep a copy of this form for your records.

EMPLOYER INFORMATION

Employer Name:

CAPS Check Employer ID # (XXX-##########):

REQUESTOR INFORMATION

Requestor Name:

Requestor Title:

Requestor Phone Number:

Requestor Phone Extension:

Requestor Email:

APPLICANT/EMPLOYEE INFORMATION

First Name:

Middle Name:

Last Name:

Date of Birth:

SSN (Last 4 digits):

Maiden Name/Previous Name(s)/Alias(es):

DORA License #

GENDER:

- ☐ Woman
- ☐ Man
- ☐ Transgender (Identifies as Woman)
- ☐ Transgender (Identifies as Man)
- ☐ Unknown

RACE/ETHNICITY (Check all that apply):

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hawaiian National & Pacific Islander
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ White

Home Phone *(Including Area Code)*:

Cell/Mobile Phone *(Including Area Code)*:

Work Phone *(Including Area Code)*: Work Phone Extension:

Home Email: Work Email:

Current Address Street:

Current Address City: Current State:

Current Zip/Postal Code: Current Address Start Date:

All Applicants/Employees are required to have 5 years of residential history provided. If the individual listed above has less than 5 years at their current address, please list the previous addresses for the past 5 years. Use another sheet of paper, if necessary.

Previous Address *(street number, street, unit, city, state, zip)*:

Address Start and End Dates:

Previous Address *(street number, street, unit, city, state, zip)*:

Address Start and End Dates:

Previous Employer(s) Agency Name(s):

By my signature, below, I attest that all information provided in this written authorization is true and complete. My signature authorizes the employer referenced above to request a CAPS Check to determine if I have been substantiated in an APS case as a perpetrator of physical abuse, sexual abuse, caretaker neglect, and/or exploitation of an at-risk adult. I acknowledge that the information resulting from such a check will be shared directly with the employer who may use the results to inform their hiring decision. By my signature I acknowledge that this request will flag my name to allow notification to this employer of any future substantiated findings as long as I am employed by this agency.

Signature:

CLEAR FORM PRINT

Date:

COLORADO
Adult Protective Services
CAPS Check Unit