
# 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<br>If Yes, please list position(s), program(s), dates, supervisor/Program Director: |

| | |
|---|---|
| EMPLOYER/SERVICE AGENCY: | |
| ADDRESS: | PHONE: ( ) |
| DATES:<br>**From_____ To_____** | SUPERVISOR: |
| DUTIES AND RESPONSIBILITIES: | |
| REASON FOR LEAVING: | |
| MAY WE CONTACT THIS EMPLOYER/SERVICE AGENCY FOR A REFERENCE CHECK? YES/NO<br>If "NO", why? | |

| | |
|---|---|
| EMPLOYER/SERVICE AGENCY: | |
| ADDRESS: | PHONE: ( ) |
| DATES:<br>From _____ To_____ | SUPERVISOR: |
| DUTIES AND RESPONSIBILITIES: | |
| REASON FOR LEAVING: | |
| MAY WE CONTACT THIS EMPLOYER/SERVICE AGENCY FOR A REFERENCE CHECK? YES/NO<br>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): _____ DORA License # _____

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

_____

**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: _____ Date: _____