



# PROVIDER APPLICATION

Name \_\_\_\_\_ Email \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

How long have you lived in Montana? \_\_\_\_\_

If less than one year, please list previous state \_\_\_\_\_

## I. SERVICE INFORMATION

After reading the descriptors, which of the following are you interested in?

Lifespan Respite Provider

Habilitation Aide

Homemaker Services

***If you would like your name placed on the Lifespan Respite Provider List, please complete Sections II and III. Otherwise skip to Section IV.***

## II. LIFESPAN RESPITE PROVIDER

Are you interested in providing services:

In your home

In the individual 's home

Overnight in your home

Overnight in individual 's home

In a community setting

*If you are interested in providing services in your home:*

Is your home accessible to a person with a disability?  Yes  No

Do you have smoke detectors in your home?  Yes  No

Do you have any pets?  Yes  No  
If yes, what kind? \_\_\_\_\_

Is your yard fenced?  Yes  No

**III. Please list the hours you are available to provide care.**

<u>DAY</u>	<u>MORNING</u>	<u>AFTERNOON</u>	<u>EVENING</u>	<u>OVERNIGHT</u>
Sunday	_____	_____	_____	_____
Monday	_____	_____	_____	_____
Tuesday	_____	_____	_____	_____
Wednesday	_____	_____	_____	_____
Thursday	_____	_____	_____	_____
Friday	_____	_____	_____	_____
Saturday	_____	_____	_____	_____
Summer only	_____	_____	_____	_____

***Please contact DEAP if there is a change in your schedule***

List any other information that applies to your work schedule.

\_\_\_\_\_

**IV. CONSUMER INFORMATION**

Are you willing to provide services to:

Infants     Young Children     Teens     Adults     Elderly

Are you willing to provide services to individuals with these special needs:

- |   |  |
|---|--|
| <input type="checkbox"/> Developmental Disabilities     | <input type="checkbox"/> Physical Disabilities         |
| <input type="checkbox"/> Mental or Emotional Issues     | <input type="checkbox"/> Chronic or Terminal Illnesses |
| <input type="checkbox"/> Foster Care or Adoption Issues | <input type="checkbox"/> Domestic Violence Issues      |
| <input type="checkbox"/> Substance Abuse Issues         | <input type="checkbox"/> Aging Issues                  |
| <input type="checkbox"/> Alzheimer=s Disease            | <input type="checkbox"/> At Risk / Crisis Care         |
| <input type="checkbox"/> Behavioral Issues              | <input type="checkbox"/> Total Care                    |

Do you have lifting restrictions? \_\_\_\_\_

**V. TRAINING INFORMATION**

<u>Training</u>	<u>Date Expires</u>
<input type="checkbox"/> CPR	_____
<input type="checkbox"/> First Aid	_____
<input type="checkbox"/> Med Certification	_____
<input type="checkbox"/> Nurses Aide (CNA)	_____
<input type="checkbox"/> LPN or RN	_____
<input type="checkbox"/> Home Health Certified	_____

*(Please provide a copy of your license or certification for our files)*

Please describe any other training, education or work experience, paid or volunteer, that you have had.



**VI. VEHICLE INFORMATION** *(Please provide proof of insurance and driver's license)*

Do you have a reliable means of transportation?     Yes     No

Do you have liability insurance?     Yes     No

Do you have a valid MT driver's license     Yes     No

**VII. REFERENCES**

Please list three previous work-related references – supervisors, not co-workers.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Relationship to you \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Relationship to you \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Relationship to you \_\_\_\_\_

How did you hear about DEAP/Lifespan Respite? \_\_\_\_\_

There is no substantiation of abuse or neglect on my child or adult protective services record.

*I, the undersigned, certify that the information I have given is the truth. I also agree to attend a mandatory orientation within 30 days of the return of a favorable background check. If I am unable to attend a scheduled orientation, I will make arrangements to go through an individual orientation with the Training and Development Specialist within the 30 days.*

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

**ADA Accommodation Statement**

*Consistent with the provisions of the Americans with Disabilities Act (ADA), applicants may request accommodations needed to participate in the application process.*

**Equal Opportunity Employer Statement**

*DEAP is an equal opportunity employer and does not discriminate on the basis of sex, race, color, age, religion, marital status, national origin, handicap or veteran status.*