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

☐ Transportation 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 <u>available</u> to provide care.

DAY	MORNING	AFTERNOON	EVENING	OVERNIGHT
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:

☐ Developmental Disabilities ☐ Physical Disabilities

☐ Mental or Emotional Issues ☐ Chronic or Terminal Illnesses

☐ Foster Care or Adoption Issues ☐ Domestic Violence Issues

☐ Substance Abuse Issues ☐ Aging Issues

☐ Alzheimer=s Disease ☐ At Risk / Crisis Care

☐ Behavioral Issues ☐ Total Care

Do you have lifting restrictions? _____

V. TRAINING INFORMATION

Training	Date Expires
☐ CPR	_____
☐ First Aid	_____
☐ Med Certification	_____
☐ Nurses Aide (CNA)	_____
☐ LPN or RN	_____
☐ 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?_____

G 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.