ARIEL
Clinical Services
Children • Families • Adults

Welcome to Ariel!

We are happy that you are applying with Ariel Clinical Services to support you in caring for the I/DD population. We take pride in the services we offer the Persons Receiving Services and Residential Providers. We admire those that collaborate with at-risk populations. We are devoted to aiding our residential providers as a team, while we support an individual shaping and embracing their optimal life journey.

In the application packet, you will find a checklist that can be used to track all the appropriate forms and information needed prior to getting a placement through Ariel. At Ariel, we offer a wide variety of waiver services for our individuals. You may provide services as a Host Home Provider/Family Caregiver, Residential Back-Up, and/or Respite Provider.

- **Host Home Provider or Family Caregiver**: An Independent Contractor who provides needed residential services in their home to people in the Home and Community Based Services – Developmental Disabilities (HCBS-DD) waiver.
- **Residential Back-Up Provider**: Provides relief to the Independent Contractor for DD waiver participants. Timeframe and pay are negotiated between the two parties.
- **CES/SLS Respite**: Provides relief to the primary caregiver. This service is coordinated through Ariel and requires a W-9 for payment.

Please understand that this process takes time. The process depends on how long it takes to submit all the required documents, background checks, and completion of training. The second part of this process is dependent upon the individuals and their guardians. All want to ensure the individual and/or guardian feels good about where their loved one will live and with whom. Each individual's path toward an Ariel Provider is unique depending on their circumstances and preferences.

- It takes approximately two weeks to process your application.
- Our goal is to align the individual's desires and requirements with a provider's strengths, skills, and lifestyle.
- You will have the opportunity to review the referral file and have your questions answered.
- The Provider and Individual have the right to choose who they will live with and give/receive support from.
- If a meet-and-greet is scheduled, you may also meet the parent or guardian, the case manager, or advocate. It is possible an individual will request to meet multiple providers at the same time, similar to a group interview.
- If the meet-and-greet goes well, we will plan a transition time for everyone to become acquainted.

<u>What to expect after you are approved</u>:

- HUD Home inspection
- Residential Provider Training: Independent Contractor, THERAP software, Mandatory Reporter, CPR/First Aid, CPI, and Medication Administration (QMAP). Other specific training or certifications may be required.
- Independent Contractor Contract signed.

We are thrilled that you are considering us to partner in your journey with this population and look forward to discussing the possibilities with you in the future.

Sincerely, *The Ariel Team*

ARIEL
Clinical Services
Children • Families • Adults

Who is Ariel?

Ariel was started in 1994 by a Special Education Teacher and a Child Psychologist as a therapeutic foster care agency. Both had a passion for children with special needs. Many children Ariel served needed ongoing support as they transitioned into adulthood. At that time, we had an individual who was developmentally delayed and was aging out of foster care who needed a host home. So, we became an Adult Services Agency in 2005. The individuals we serve have a wide range of intellectual, developmental, and physical disabilities. We specialize in matching the people we serve to dedicated and caring Residential Providers.

What does it take to be an Ariel Provider?

Ariel Residential Providers Expectations:

- Open your home and offer a nurturing and trauma-informed environment.
- Assist with personal care, meal planning and preparation, medical appointments, community activities, safety skills, shopping, and more.
- Recognize teachable moments and how to learn from them.
- Understand their rights.
- Find personal strengths.
- Be involved in their community and provide an enriched life.
- Be willing to be an Independent Contractor.

Why choose Ariel?

There are many reasons to become an Adult Residential Provider with Ariel.

- Competitive rates and continuous training and consistent support.
- Nursing, Mental health and Behavioral staff available for consultation.
- Advocacy for persons receiving services and our Residential Providers.
- Case Management staff to coordinate care, identify needs, and to support the person receiving services.
- Administrative staff to assist with benefits and money management.

Ariel's mission is to provide safe, nurturing, and supportive environments for our clients so that they may have the opportunities to develop their strengths,maximize their potential and fully participate in society.

ARIEL Clinical Services
Children • Families • Adults

Requirements for Residential Provider, Residential Back-Up & Respite

1. **Potential Provider Application:**
   - ☐ Application Packet
   - ☐ Fair Credit Reporting Act Disclosure and Authorization (for anyone over 18 in the home)
   - ☐ Release of Information and Contractor Non-Disclosure Agreement
   - ☐ Affidavit of Citizenship
   - ☐ False Claims Acknowledgment
   - ☐ Confidentiality Agreement
   - ☐ Provider Profile w/3+ Photos (Family photo, Photo of House, Photo of available bedroom).

2. **Submit Copies of:**
   - ☐ Copy of Driver's License (for anyone over 18 in the home)
   - ☐ Home/Renters Insurance
   - ☐ Auto Insurance (for any vehicle that will transport an individual)
   - ☐ Professional Liability Insurance (can be obtained once an individual is placed in the home)

3. **Technology Requirements**
   - ☐ Laptop/Desktop Computer
   - ☐ Internet & Wi-Fi
   - ☐ Working email address

4. **Schedule Required Trainings or Submit Certificates:**
   - ☐ CPR & First Aid
   - ☐ Safety Care or CPI
   - ☐ QMAP - $20 fee
   - ☐ Person Centered Training (PCT)

     Residential Providers Only:
     - o Host Home Provider Onboarding
     - o Ariel Policy and Procedure Training

5. **Schedule with Residential Program Manager:**
   - ☐ Meet and Greet
   - ☐ HUD (Home) Inspection (completed with Placement Coordinator)

6. **CES/SLS Respite Providers ONLY:**
   - ☐ W-9 Form

Residential Back-Up and Respite will have additional fees for training. Contact Ariel Offices for fee information at 970-208-9876.

ARIEL
Clinical Services
Children • Families • Adults

This page is intentionally left blank.

ARIEL
Clinical Services
Children • Families • Adults

Residential Provider Application

Service(s) Applying for (check all that apply):

☐ Host Home ☐ Residential Back-Up ☐ CES/SLS Respite

Full Name of Prospective Provider: _____

Home Address: _____

Mailing Address (if different): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Educational Background (High School, College, Graduate, Trade):

Name of School	Location	Field of Study	Graduation Date

Work & Independent Contractor History (most recent or current employer first):

Name of Company/Agency:	**Address/Phone:**
Dates Worked:	**Position Held/General Duties:**
Reason for Leaving: **Okay to contact? YES NO**	**Name/Title of Direct Supervisor:**

Name of Company/Agency:	**Address/Phone:**
Dates Worked:	**Position Held/General Duties:**
Reason for Leaving: **Okay to contact? YES NO**	**Name/Title of Direct Supervisor:**

ARIEL
Clinical Services
Children • Families • Adults

Name of Company/Agency:	**Address/Phone:**
Dates Worked:	**Position Held/General Duties:**
Reason for Leaving: **Okay to contact? YES NO**	**Name/Title of Direct Supervisor:**

1. Is everyone in your home currently vaccinated against COVID-19? ☐YES ☐NO

2. Have you ever been convicted of a felony or misdemeanor? ☐YES ☐NO
   If yes, please explain and give date:

   _____

   _____

3. Have you ever been charged with or convicted of any benefit program (Medicaid/Medicare, SSI, Food Assistance, etc.) abuse or fraud? ☐YES ☐NO
   If yes, please explain and give date(s).

   _____

   _____

4. Have you ever been accused or convicted of Abuse to an at-risk Adult? ☐YES ☐NO
   If yes, please explain and give date(s).

   _____

   _____

5. How did you become aware of us? _____

6. What interested you in becoming a Residential Provider and what are your goals?

   _____

   _____

   _____

ARIEL
Clinical Services
Children • Families • Adults

7. Have you ever been a residential provider or foster parent before? If so, please identify the agency with whom you contracted.

8. What is your understanding of the role of the Residential Provider?

9. Please describe your prior experience, if any, working with individuals with developmental disabilities as well as any other qualifications or training that might prepare you to be a residential provider (include any current licensures or certifications):

10. Have you identified a specific individual that you would like to provide a host home for? If so, describe your current relationship with him/her (i.e. how you came to know him/her, activities that you currently engage in together, present involvement with your family, etc.)

11. If you have not identified a specific individual, describe in detail the type of individual that you think would fit well in your home. Please note if you are willing to serve individuals with high needs (i.e., behavioral, medically fragile, non-ambulatory, and SOMB specific individuals).

12. Identify the other members of your household (include ages, occupations):

13. Briefly describe your home. List features such as stairs, ranch style, wheelchair accessibility, special amenities such as spare rooms, fenced yards, recreational areas, etc.

Bedrooms: _____ Bathrooms: _____ Square Footage of Home: _____

14. The agency is required to conduct a criminal background check on all individuals in the residential home eighteen (18) years of age or older. Please identify former charges and explain the court's ruling.

15. Have you used any illegal drugs in the last six months? Does any member of your household use illegal drugs? Have you ever allowed illegal drugs in your household?

_____

_____

I certify that the information provided herein is true and complete to the best of my knowledge. I understand that any provider agency considering contracting with me as a residential provider may make inquiries to verify the facts set forth in this form and to establish my qualifications to provide the services required within the contract. This includes (but may not be limited to) conducting reference and criminal background checks. I understand that any false statements, omissions, or misrepresentation may result in my being further considered as a residential provider and, if a contract has been entered, the voiding or termination of said contract.

Applicant Signature: _____

Printed Name: _____

Date: _____

ARIEL
Clinical Services
Children • Families • Adults

Provider Profile

Thank you for completing your application.

This next section is very important. It may seem redundant; however, this is the form we send to the Community Center Board (CCB) or Case Management Agencies (CMA) in response to referrals we receive. This is your opportunity to shine and separate yourself from other potential providers.

Please complete the next 3 pages in their entirety. The more information, the better. It will help the Person Seeking Placement and/or their guardian make decision about living in your home.

If you need assistance, please contact the Residential Program Manager.

ARIEL
Clinical Services
Children • Families • Adults

Ariel Residential Provider Profile

Name:
Phone Number:
Email:
Address of Home:
Describe your neighborhood:

Type of Home: ☐House ☐Apartment ☐Townhome ☐Other _____

Is your home wheelchair accessible? ☐Yes ☐No

Do you have a wheelchair accessible vehicle? ☐Yes ☐No

How many available bedrooms? _____

On what level are the available rooms (basement, ground, second, etc.)? _____

Do you have outdoors space available (yard, nearby park, etc.)? _____

Are you able to work with people receiving services that are? (Circle your answer)

Male / Female / Both

Children / Adults / Both

Number pets in the home:

____ Dogs

____ Cats

____ Other (please identify): _____

Do you or other members of the household smoke? ☐Yes ☐No

Would individuals be able to smoke in the home or in a designated area? ☐Yes ☐No

If no, please explain:

_____

_____

Does your family eat dinner together every night or separately? _____

Do you practice a particular religion in your home? (If yes, please explain) _____

_____

Are you open to having pets in your home? ☐Yes ☐No

Are you available to provide Out-of-Home care? ☐Yes ☐No

ARIEL
Clinical Services
Children • Families • Adults

Are you available to provide In-Home care? ☐Yes ☐No

Describe one difficult experience (relevant to this position) that you've had, where you were proud of how you handled it:

Describe a positive memory you have had while working with people in services.

Describe your strengths as a provider:

Describe your weaknesses:

Is there any other helpful information to match you with a person receiving services? (Interests, skills, experience, etc.)

ARIEL
Clinical Services
Children • Families • Adults

Are you able to serve medically fragile individuals (G-tube, non-verbal, etc.)? ☐Yes ☐No

Have you worked as a CNA, RN, or other related field? ☐Yes ☐No

Are you able to serve Sex Offenders? ☐Yes ☐No **Are you SOMB trained?** ☐Yes ☐No

Are you able to serve individuals with High Behaviors? ☐Yes ☐No

Do you hold certifications and experience with individuals that present behavioral challenges? ☐Yes ☐No

If yes, list all certifications and/or explain experience:

_____

_____

Can you provide close and constant supervision? ☐Yes ☐No

List everyone living in your home (adults, children, family members, friends):

First Name or Initials	Age	Sex	Relationship to Provider

Is anyone you have listed in your home currently receiving services from: Foster Care, SLS, EBD, or CHRP?
☐Yes ☐No

If yes, list all individuals and their waiver services under your care:

First Name or Initials	Age	Sex	Waiver Service(s)

Describe your experience as a care provider (i.e.: past employment, care-giver experience, etc.):

ARIEL
Clinical Services
Children • Families • Adults

Do you and other members of the household have other jobs? If so, what are they and are they full-time, part-time, etc.?

Describe a typical weekday in your home:

Describe a typical weekend in your home:

PLEASE INCLUDE PHOTOS OF:

1. You and/or your family
2. Exterior of the Home – Front and Back
3. All Common Living Areas (kitchen, dining, bathroom, living, etc)
4. Potential Bedroom for Person Receiving Services

Photos can be submitted with application or emailed to designated Ariel staff.

ARIEL
Clinical Services
Children • Families • Adults

Reference Checks

Prospective Provider Name: _____

Please provide five (5) references in the event two (2) references do not respond.

Name	Relationship	Phone Number

Signature: _____

Printed Name: _____

Date: _____

ARIEL
Clinical Services
Children • Families • Adults

Host Home Confidentiality Agreement

Ariel Clinical Services has a legal and ethical responsibility to safeguard the privacy of all individuals and to protect the confidentiality of their records.

In the course of being an Independent Contractor with Ariel Clinical Services, I understand I may come into possession of confidential information about people receiving services, even though I may not be directly involved in providing those services.

I understand such information must be maintained in the strictest confidence. I hereby agree that I will not, at any time during or after my agreement with Ariel Clinical Services, disclose any individual's information to any person whatsoever or permit any person to examine or make copies of any reports or other documents prepared by me, unless directed by Ariel.

When an individual's information must be discussed with other professionals involved in the care, I will use discretion to ensure such conversations cannot be overheard by others who are not involved in the person's care. This includes but not limited to restaurants, community activities, shopping centers, etc. I will also ensure a Release of Information is signed by the individual or their guardian allowing for the exchange of information.

I understand it is a breach of confidentiality to post any information pertaining to an individual, an individual's family, history, or case on the internet. This includes photos, names, and any other content about the individual on any social media sites such as Facebook, Instagram, Twitter, TikTok etc..

I understand I am responsible for ensuring the protection of this information with other members of my household, guests, friends, and/or family members.

I understand that violations of this agreement may result in immediate closure of my home.

_____ _____

Signature Date

_____ _____

Signature Date

FAIR CREDIT REPORTING ACT DISCLOSURE & AUTHORIZATION DISCLOSURE

As an applicant for becoming a Host Home with Ariel Clinical Services, you are a consumer with rights under the Fair Credit Reporting Act. When any of the following circumstances exist, Ariel Clinical Services, may choose to obtain and use information contained in either a consumer report or an investigative consumer report from a consumer reporting agency about you: (1) when considering your application to be an independent contractor, (2) when making a decision whether to offer you a contract, (3) when deciding whether to continue your contractor status (if you are selected), or (4) when making other contract-related decisions directly affecting you.

For explanation purposes, a "consumer reporting agency" is a person or business which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly assembles or evaluates consumer credit information or other information on consumers for the purpose of furnishing consumer reports to others, such as Ariel Clinical Services.

A "consumer report" means any written, oral or other communication of any information by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing your eligibility for employment purposes.

An "investigative consumer report" means a consumer report or portion thereof in which information on your character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with your neighbors, friends, associates or others with whom you are acquainted or who may have knowledge concerning any such items of information.

An investigative consumer report may be requested by Ariel Clinical Services. You may request, in writing and within a reasonable time, additional disclosures regarding the nature and scope of the investigation requested as well as a written summary of your rights under the Fair Credit Reporting Act.

Authorization

By signing below, I, _____, hereby voluntarily authorize Ariel Clinical Services, to obtain either a consumer report or an investigative consumer report about me from a consumer reporting agency and to consider this information when making decisions regarding my contractor status at Ariel Clinical Services. I understand that I have rights under the Fair Credit Reporting Act, including the rights discussed above.

This requires the following background checks:

- ✓ Criminal Background Investigation (CBI)
- ✓ Colorado Adult Protective Services (CAPS)
- ✓ CBI Sex Offender Background Check
- ✓ Office of Inspector General
- ✓ National Sex Offender Background Check
- ✓ Reference check
- ✓ Driver's License Record
- ✓ Drug Screen

Background checks are reviewed annually.

_____ _____

Signature Date

_____ _____ _____

Social Security Number Driver's License Number Date of Birth

False Claims Prohibition and Acknowledgment

The purpose of this policy is to comply with the Deficit Reduction Act of 2005 by ensuring that employees of Ariel Clinical Services and of Ariel Clinical Services contractors and agents provided detailed information about the False Claims Act, 31 USC s 3729-s 3733, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, and any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of these laws in preventing and detecting fraud, waste and abuse of federal health care programs.

1.0 COMPLIANCE WITH FALSE CLAIMS LAWS REQUIRED

1.1 Federal Law Prohibits False Claims. The Federal False Claims Act, 31 USC 3729-3733 (FCA), prohibits the submission of false or fraudulent claims for payment to Medicare, Medicaid or other federal health programs. They are as follows:

1.1-1 Under the FCA, a person is civilyl liable if he or she:

1.1.1 1 Knowingly presents, or causes to be presented, to an officer or employee of the united States Government a false or fraudulent claim for payment or approval;

1.1.1.2 Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approve by the Government;

1.1.1.3 Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

1.1.1.4 Has possession, custody, or contror of property or money used, or to be used by the Governmeni, and intending to defraud the Government or willfully to conceal the property, delivers or causes to be delivered, less property than ithe amount for which the person person receives a certificite or receipt;

1.1.1.5 Authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

1.1.1.6 Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government who lawfully may not sell or pledge the property; or

1.1.1.7 Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or trasmit moeny or property to the Goverment.

1.1.2 A civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damanges wich the Goverment sustains becuase of the act of that peron can be awarded.

1.1 3 The terms "knowing" and "knowingly" mean that a person, with respect to information -

1.1.3.1 Has actual knowledge of the information;

1.1.3.2 Acts in deliberate ignorance of the truth or falsity of the information; or

1.1.3.3 Acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

1.1.3 4 "Claim"- includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of tho money or property which is requestcd or demanded.

1.1.3.5 Exclusion - This does not apply to claims, records, or statements made under the Internal Revenue Code of 1986, which has it's own statues and regulations.

1.1.3.6 The FCA allows individuals who have first-hand knowledge of such misconduct to sue the entity that submitted the false claim on behalf of the United States. If the suit results in recovery of funds for the Government, the individual can share in a percentage of the recovery. If the suit is found to have been for the purpose of harassing the employer, and/or the case has no merit, the individual may have to pay the defendant for its legal fees and the costs of its defense.

1.1.3.7 The FCA protects employees who act as whistleblowers form retaliation by their employers. An employee may not be discharged, demoted, suspended, threatened, harassed or discriminated against in the terms and conditions of employment because of lawful actions taken by the employee in connection with an action under the FCA. If the employee can demonstrate that he or she was the victim of such retaliation, the employee is entitled to reinstatement, double back pay, plus interest and reimbursement of other costs and damages.

I.2 Federal Administrative Remedies for False Ctaims, 31 USC 3801-3812

1.2.1 This federal law is similar to the FCA and creates a penalty for submitting a false claim of up to $5,000 per claim and twice the amount of the claim. This law is violated when a false claim is submitted, not when its paid. Under this statute, investigations and recoveries are handled by federal agencies, not the courts. Although private individuals may report violations to the government, there is no option for the whistleblowers to share in the amounts recovered.

2.0 PROCEDURE FOR HANDLING ALLEGED FALSE CLAIMS

2.1 Duty to Report - to assist Ariel Clinical Services with its commitment to appropriate and legal conduct in relation to federally funded programs, employees or Ariel Clinical Services and of contractors have a duty to report any violations of the above laws that come to their attention. For example, if an employee believes that a representative or contractor of Ariel Clinical Services is billing for services that were not actually provided, were improperly coded, were medically unnecessary, or were provided in a significantly substandard manner, the employee or contractor employee should immediately contact the Human Resources Director, the Director of Finance, or the Executive Director of Ariel Clinical Services. The report should be in writing and contain details of the nature of the violation, date, time, location, identity of person engaging in the conduct, identity of any witnesses and relevant documents. The person receiving the report shall immediately notify the Compliance Officer (Director of Finance) of Ariel Clinical Services of the reported violation.

2.2 Investigation. Ariel Clinical Service's Compliance Officer, or the Compliance Officer's designee, shall conduct an investigation of the alleged misconduct. Employees and contractors must cooperate with the investigation.

2.3Confidentiatly and Retaliation Issues. Ariel Clinical Services can not promise confidentiality in conducting its investigation, although it will endeavor to keep the investigation as confidential as possible while not jeopardizing the investigation. No employees shall be retaliated against for making a good faith report of a suspected violation to the managers identified above, or to any state or Federal agency authorized to receive such report, or for participating in the investigative or legal piocess. There are specific precautions under the laws for employees and contractors who act as "whistleblowers" when they believe false or fraudulent claims are being submitted.

2.4 Penalty. In addition to the civil penalties and damage awards that an individual may suffer for violating the Federal laws prohibiting False Claims and retaliation for reporting false claims, any employee of Ariel Clinical Services who violates this policy will also be subject to discipline or discharge for the first offense. Contractors and agents who violate this policy shall be in breach of their contract and subject to cancellation as well as monetary liability to Ariel Clinical Services for any damages Ariel Clinical Services suffers as a result of the Contractor's or agents violations.

3.0 DISSEMINATION OF POLICY

3.1 Ariel Clinical Services shall disseminate this policy to all employees at the time they are hired and to contractors and agents at the time they enter into a contract with Ariel Clinical Service and shall require the contractors and agents to make their employees and subcontractors aware of the policy. This policy shall also be included in Ariel Clinical Service's Policy Manual that is available to all Board Members, Managers and Employees. It shall be reviewed periodically with employees to ensure awareness and compliance.

FALSE GLAIMS ACKNOWLEDGEMENT

I have read and understand the False Claims Prohibition Policy developed by Ariel Clinical Services.
A copy of the False claims prohibition policy has been provided to me.

_____ _____

Signature Date

_____

Printed Name

AFFIDAVIT

for the Colorado Department of Human Services and the Department of Health Care Policy and Financing as Proof of Lawful Presence in the United States

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

___ I am a United States citizen, or

___ I am a legal Permanent Resident of the United States, or

___ I am lawfully present in the United States pursuant to federal law.

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

_____ _____

Signature **Date**

ARIEL
Clinical Services
Children • Families • Adults
2938 North Avenue, Suite G Grand Junction, CO 81504
970-208-9876 FAX: 970-242-3435

Non-Disclosure Agreement

ARIEL CLINICAL SERVICES has a legal and ethical responsibility to safeguard the privacy of all clients and to protect the confidentiality of their records.

In the course of my contract at ARIEL CLINICAL SERVICES, I may come into possession of confidential client information, even though I may not be directly involved in providing client services. I understand that such information must be maintained in the strictest confidence.

As a condition of my contract, I hereby agree that, unless directed by my case manager or other Ariel employee, I will not at anytime during or after my contract with ARIEL CLINICAL SERVICES, disclose any client information to any person whatsoever or permit any person whatsoever, to examine or make copies of any client reports or documents, other than as necessary in the course of my contract.

When client information must be discussed with other health care practitioners in the course of my work, I will use discretion to ensure that such conversations cannot be overheard by others who are not involved in the client's care.

I understand that violation of this agreement may result in corrective action, up to and including discharge.

_____ _____

Signature Date

_____ _____

Signature Date

CAPS Check Request Form

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).

Incomplete or unsigned requests AND/OR requests without full payment of the fee will not be processed and will be returned. Payment must be made with a check or money order for $15.50 per employee payable to CAPS Check Unit. Please note: Cash payments will not be accepted and the request will be returned.

Mail your completed request to:

Colorado Department of Human Services
Division of Aging and Adult Services
CAPS Check Unit
1575 Sherman St., 10th Floor
Denver, CO 80203

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 the 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 I have received written authorization from the employee/applicant to conduct this CAPS Check. My signature also confirms that I acknowledge that this request will flag this employee/applicant for any future substantiated findings, and if the employee/applicant is still employed by me or my agency at that time, notification of the substantiated finding(s) will be provided to me or my agency. I affirm that I am authorized by Section 26-3.1-111(7), C.R.S. to request this CAPS check and all information provided in this request is true and accurate to the best of my knowledge.

Signature: _____

Date: _____

CLEAR FORM PRINT

COLORADO
Adult Protective Services
CAPS Check Unit