



# Provider Application

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

- Residential Provider     
  Residential Back-Up     
  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):

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

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



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

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

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2. 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).

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

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4. How did you become aware of us? \_\_\_\_\_

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

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6. Have you ever been a Residential Provider or Foster Parent before? If so, please identify the agency with whom you contracted.

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7. What is your understanding of the role of the Provider?

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8. 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):

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9. Have you identified a specific individual that you would like to provide services 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.)

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10. 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).

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

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

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Bedrooms: \_\_\_\_\_ Bathrooms: \_\_\_\_\_ Square Footage of Home: \_\_\_\_\_

13. 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.

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14. 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?

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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 provider and, if a contract has been entered, the voiding or termination of said contract.

Applicant Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_



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: \_\_\_\_\_



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 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.



<b>Name:</b>
<b>Phone Number:</b>
<b>Email:</b>
<b>Address of Home:</b>
<b>Describe your neighborhood:</b>

**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 outdoor space available (yard, nearby park, etc.)?** \_\_\_\_\_

**Are you able to work with Members 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:

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**Does your family eat dinner together every night or separately?** \_\_\_\_\_

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

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

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

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



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 experience with individuals that present behavioral challenges? Yes No

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

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Can you provide close and constant supervision? Yes No

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

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

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Describe your strengths as a provider:

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Describe your weaknesses:

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

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

First Name or Initials	Age	Sex	Relationship to Provider

Is anyone in your home currently receiving waiver services?  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.):

**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.*