Community Access Program

PO Box 222, Rutland VT 05702

Shared Living Provider Application

Applicant:			Date:
Co- Applicant:			
Mailing Address:			
City:		State:	Zip Code:
Physical Address:			
City:		State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	
Email Address:			

Do you live in a: ☐ House ☐ Condo ☐ Apartment ☐ Mobile/Modular Home ☐ Other?
Do you: ☐ Rent ☐ Own? Do you have homeowner's or renter's insurance? ☐Yes ☐No
If you rent your home, do you have landlord approval to have a non-related individual move into your home?
☐ Yes ☐ No ☐ haven't asked yet

Have you resided in any state other than Vermont? ☐ Yes ☐ No
If yes, where, when and for how long?_____
_____
How many times have you moved in the last 5 years? _____

Have you ever been a Home Provider for an individual(s) with an intellectual disability?
☐ Yes ☐ No
If yes, for what Agency? _____

Household Composition: List ALL household members Place an * next to the name of any Co-Applicants who will assist in providing care. (All individuals age 18 or over who live in or stay overnight in your home on a regular basis must complete all required background checks.)

Name	Gender	DOB	Relationship to you	Where Living?

Are there persons who visit your home on a regular basis (weekly, monthly, school breaks, etc) throughout the year? ☐ Yes ☐ No
If yes, please elaborate (ages, gender, relationship, frequency of visits, etc): _____
_____

Do you provide care in your home to any other vulnerable individuals (aged or disabled family members, foster children, or agency placed) at this time?
If yes, please elaborate: _____
_____

Describe your home (location, setting, land, etc): _____
_____
_____
_____
Number of stairs to enter your home: _____
Is your home wheelchair accessible? ☐ Yes ☐ No
Number of rooms: _____ Number of bedrooms: _____
Number of floors: _____
On which floor will the bedroom for an individual placed in your home be located? _____
Do you have additional rooms/separate bathroom, etc that the individual placed in your home could have exclusive use of? (such as a mother-in-law suite or efficiency apartment). ☐Yes ☐No
If yes, please describe: _____
_____
Are there any pets in your home or on the property? ☐ Yes ☐ No
If yes, please elaborate (type, number): _____
_____
I can make accommodations (gates, etc) to ensure my pet's safety. ☐ Yes ☐ No
Are any guns kept in your house? ☐ Yes ☐ No
If yes, where are they kept? _____
Are alcoholic beverages kept in your house? ☐ Yes ☐ No
If yes, how are they stored? _____
How are prescription or over-the-counter medications stored in your home? _____
_____
Does anyone smoke in your home? Yes No
I have cable/satellite TV? ☐ Yes ☐ No I have Internet access? ☐ Yes ☐ No

Driver Record Information

As part of our standard recruitment and screening process we ask that all applicants complete this section, the purpose of which is to assist RMHS/CAP in complying with various internal and external policies and regulations, and to protect the safety and well-being of the individuals we serve, as well as our contractors.

Primary Applicant	Co-Applicant
Do you currently possess a valid driver's license? ☐ yes ☐ no	Do you currently possess a valid driver's license? ☐ yes ☐ no
Do you have the minimum vehicle insurance required by the State of Vermont? ☐ yes ☐ no	Do you have the minimum vehicle insurance required by the State of Vermont? ☐ yes ☐ no
Have you had any violations in the past 5 years, including DUI/DWI, Speeding, License Suspension, Accident, and/or Careless and Negligent Operation? ☐ yes ☐ no	Have you had any violations in the past 5 years, including DUI/DWI, Speeding, License Suspension, Accident and/or Careless and Negligent Operation? ☐ yes ☐ no
If yes, please explain:	If yes, please explain:

Education and Skills

State of Vermont DDSD Regulations require that Shared Living Providers have a High School diploma or equivalent, unless a written variance is obtained in writing from DDSD. A variance can be requested by CAP during the application process and is justified based on each individual placement and circumstance.

Primary Applicant	Co-Applicant
Do you possess a high school diploma or GED equivalent? ☐ yes ☐ no	Do you possess a high school diploma or GED equivalent? ☐ yes ☐ no
Name of High School and Town/State:	Name of High School and Town/State
Other Education:	Other Education:

List all certifications, training or experience relevant to providing support to an individual with a disability:

Subject: _____ Date: _____
Subject: _____ Date: _____
Subject: _____ Date: _____
Subject: _____ Date: _____

Employment History

Please indicate your current employment status, and list your three most recent employers, beginning with your current employer.

Primary Applicant	**Spouse/Domestic Partner**
I am currently: ☐ employed ☐ unemployed and looking for work ☐ working at home I work_____ hours per week. My work hours are from _____ to _____	I am currently: ☐ employed ☐ unemployed and looking for work ☐ working at home I work_____ hours per week. My work hours are from _____ to _____
Current Employer:	**Current Employer:**
Address:	Address:
Phone:	Phone:
Job Title:	Job Title:
Supervisor's Name:	Supervisor's Name:
Salary:	Salary:
Date Hired:	Date Hired:
Previous Employer:	**Previous Employer:**
Address:	Address:
Phone:	Phone:
Job Title:	Job Title:
Supervisor's Name:	Supervisor's Name:
Salary:	Salary:
Dates of Employment:	Dates of Employment:
Previous Employer:	**Previous Employer:**
Address:	Address:
Phone:	Phone:
Job Title:	Job Title:
Supervisor's Name:	Supervisor's Name:
Salary:	Salary:
Dates of Employment:	Dates of Employment:

SUPPORT PROFILE

Please choose ☑ the answer that best reflects your response to each statement. There is no right (or wrong) answer to any of these statements and an inability or unwillingness to provide some types of support does not reflect poorly upon you as an applicant. This questionnaire merely helps us to get to know you so that we can make the best possible match for the individuals we support.	**I cannot do that (time, safety issues, limited resource, etc.)**	**I am not willing to do that (moral or religious beliefs).**	**I am not sure.**	**I would consider doing that with more info, training or support.**	**I can definitely do that.**	**N/A – not applicable**
HEALTH/PERSONAL CARE						
I am willing to support someone needing hands on personal care.						
I am willing to support a person who uses a wheelchair and requires assistance to transfer/move.						
I am willing to support someone who is incontinent of bladder/bowel.						
I am willing to support someone needing special communication skills/devices.						
I am willing to support a person who requires periodic attention due to sleep disturbance.						
I am willing to support an individual who experiences/shows sloppiness or poor personal hygiene						
I am willing to support an individual who experiences/shows depression.						
I am willing to support an individual who overeats or is constantly eating.						
I am willing to support an individual who refuses to take medication on occasion.						
DIET AND EXERCISE						
I am willing to prepare personalized (different food or time) meals including special nutritional requirements around cholesterol, diabetes, etc.						
I am willing to support someone to engage in regular physical activity by making equipment/opportunities available.						
I am willing to engage in regular physical activity alongside someone living in my home.						
SOCIAL						
I am willing to learn/help support an individual needing a high level of support and supervision.						
I would include an individual in visits in my home with extended family.						
I would include an individual on trips to visit my extended family in their homes.						
I can forgive a serious act of aggression directed to me.						
I can forgive a serious act of aggression against my partner.						
I can forgive a serious act of aggression against my child(ren).						
I can forgive a serious act of aggression against my pets.						
I am willing to welcome an individual's friends into my home regularly.						
I am willing to welcome an individual's friends whom I dislike into my home.						

Please choose ☑ the answer that best reflects your response to each statement. There is no right (or wrong) answer to any of these statements and an inability or unwillingness to provide some types of support does not reflect poorly upon you as an applicant. This questionnaire merely helps us to get to know you so that we can make the best possible match for the individuals we support.	**I cannot do that (time, safety issues, limited resource, etc.)**	**I am not willing to do that (moral or religious beliefs).**	**I am not sure.**	**I would consider doing that with more info, training or support.**	**I can definitely do that.**	**N/A – not applicable**
I am willing to sometimes attend/participate in activities that I don't enjoy because the person I support does enjoy them and wants to do them with me.						
I am willing to change my leisure habits to accommodate the interests of an individual I support.						
I am willing to place controls on TV/Internet access.						
SPIRITUALITY						
I am willing to take someone to a weekly religious service of their choosing.						
I would allow an individual to stay home, if they chose, rather than attend my service.						
SEXUALITY						
I can talk to an individual about his/her physiology and masturbation.						
I can answer a person's questions about sexual matters factually, without conveying a sense of moral approval or disapproval.						
I can allow the use of sexual aids (pornography, toys, etc.) in my home.						
I can be supportive of an individual's heterosexual or gay/lesbian romantic/sexual relationships.						
I am willing to allow an individual to have sex in my home after team discussion/approval.						
BEHAVIORAL						
I am willing to support an individual who experiences/shows physical expressions of frustration/anger.						
I am willing to support an individual who experiences/shows verbal aggression towards myself or others (may include using profanity, vulgar or insulting language).						
I am willing to support an individual who experiences/shows hyperactivity.						
I am willing to support an individual who hurts self through pinching, biting, or head banging.						
I am willing to support an individual who experiences/shows difficulty in communicating with words.						

APPLICANT HOBBIES AND INTERESTS						
Using a ☑, please tell us how often you (your family) typically engage in the following activities. **ACTIVITES AND INTERESTS**	**Never**	**Rarely (1-2 times per year)**	**Sometimes (once every 2-3 months)**	**Regularly (about 1x a month**	**Often (weekly/daily)**	**Willing to try it.**
Going out to a movie						
Renting/watching a movie at home						
Watching television						
Attending concerts						
Attending plays						
Attending organized sporting events (what kind?)						
Participating in organized sporting events (who, what kind?)						
Attending religious services (where)						
Visiting neighbors, or having neighbors over for a visit						
Traveling (more than an hour) to see family or friends						
Visiting local family or friends						
Attending local functions (church suppers, dances, etc.)						
Bingo, or similar, organized game nights						
Yard or garage sales						
Attending car races						
Reading						
Visiting the library						
Outdoor exercise (walking, skiing, running, etc.)						
Camping						
Hiking						
Fishing						
Hunting						
Boating						
Volunteer activities (Meals on Wheels, Green-Up Day, etc.)						
Surfing the web						
Arts and Crafts						
Game night at home						

HOBBIES AND INTERESTS What hobbies or interests do you or members of your family/household have that may be useful in caring for someone in your home?		
Applicant	Co-Applicant	Others

Is there anything else you would want us to know about your family in order to make the best possible placement in your home? _____
_____
_____
_____

Do you have any questions or concerns that you would like answered or addressed as part of the application process? _____
_____
_____
_____

References:

Please complete the front page of the following 4 pages with the name and complete mailing address of 4 references, who do not live with you and to whom you are not related. References should be someone who has known you for at least 2 years. Please ensure that you sign each form and only complete the front page of each reference form. The forms will be mailed to your references for completion.

REFERENCES

The Community Access Program is a private non-profit Designated Service Agency that provides support to adults and children with a developmental disability. We are designated by the State of Vermont, Developmental Disability Services Division.

Shared Living is a model of support through which an individual with a disability becomes part of his or her community and develops and enjoys long-term, meaningful relationships. Shared Living Providers invite a person into their lives and offer love and support in addition to a safe and comfortable home. The goal is to establish an environment of growth and acceptance where lasting relationships occur as an individual experiences a sense of home and belonging and becomes integrated into the social experiences that shared living provides.

The person named below has applied to the Community Access Program (CAP) to become a contracted Shared Living Provider and has given us permission to check references. We would sincerely appreciate you providing the information requested and any additional comments which will assist us in evaluating his or her character and ability to provide such care. Any information furnished should be returned in the enclosed postage paid envelope to the Community Access Program at PO Box 222, Rutland, VT 05702. All information received will be held in the strictest of confidence.

Thank you, in advance of your assistance in this matter. Please direct any questions about this reference to the Shared Living Home Developer at 786-7339.

_____ _____

Name of Potential Contractor Maiden Name or Alias

I authorize _____, whose full mailing address is _____

_____, to provide an opinion of my suitability for

providing contractual services for an individual with a disability. I have read and understand the contents of this form. With this authorization, I hereby release you and the Community Access Program from any and all liability for providing this information regardless of the truth or falsity thereof.

_____ _____

Signature of Provider Applicant Date

Personal Reference (continued):

1. Would you recommend this person as a potential contractor? ☐ Yes ☐ No
2. How long have you known this person/family? _____
3. Describe in what capacity and how well you know the potential contractor(s): _____
   _____
4. Please provide your opinion of the potential contractor's ability to provide in home care for a vulnerable person with special needs and to act as an appropriate role model for someone who may need help with social skills. Please comment on any special skills and interests they have which might enrich a person's life. _____
   _____
5. What kind of person do you feel the potential contractor(s) would best be able to share their life/lives with; i.e. male/female, active/sedentary, verbal/non-verbal, etc? _____
   _____
6. Is there any type of person with special needs whom you feel would not do well with the potential contractor/family; i.e. challenging behaviors, personal care/hygiene needs, extreme medical challenges, etc? _____
   _____
7. Please describe what you know about the potential contractor's individual personality and their relationships within their home, family and community. _____
   _____
8. Do you have any reservations about this individual/family providing contractual services? ☐ Yes ☐ No Comments (health problems, family difficulties, addiction problems, etc.). _____
9. If a person you loved needed a supported residential environment, would you consider the potential contractor(s) to provide that care? ☐Yes ☐ No Why or why not? ____
   _____
10. Any additional comments? _____
    _____

Please provide a telephone number in case we need to contact you for clarification or further questions. _____

Please sign and date your reply.

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Please sign and date your reply.

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Signature of Reference Date

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Printed name of reference

I certify that the aforementioned information is true to the best of my knowledge. I understand that any false statements made or false answers given in this application shall be grounds for automatic denial of my application and automatic termination of my contract in the event that I am accepted as a provider.

I understand that the Community Access Program (CAP) may contact and request information from reference sources, both listed and not listed here, and from various Federal, State, or other agencies which maintain records related to driving, civil or criminal experiences. I authorize such inquiries and agree that this information is provided at my request and for my benefit. I hold any persons or organizations harmless, and do hereby release them from any and all liability for damages of any nature for furnishing any of this information.

I acknowledge and agree that, if I choose to submit this Application to the Community Access Program electronically (for example, by using the RMHS/CAP website), then- by doing so- my answers outlined above are valid, effective and binding without any signature and are granted by virtue of my submission of this application by electronic means.

Furthermore, I understand that as a contracted Home/Shared Living Provider, I will not be an employee of CAP and/or Rutland Mental Health Services, and will not be entitled to health care or other benefits afforded to agency employees.

I understand that I will be required to provide documentation of current home owner's or renter's liability insurance and automobile insurance as a condition of contracting for the situations for which I am applying.

I acknowledge that I have been offered and/or received a copy of the following disclosures related to my/our application:

- Privacy (see next page)
- Confidentiality (see next page)
- Employment Status (see next page)

_____	_____
Applicant	Co-Applicant
_____	_____
Date	Date

APPLICANT COPY

PRIVACY DISCLOSURE

The content of this application is confidential. Its use shall be limited to screening the applicants'/co-applicants' eligibility to provide home supports to prospective participants. Within that purpose, responses contained may be reviewed by the program and administrative staff of the Community Access Program. No other use of information contained in this application shall be made without the written permission of the applicant/co-applicant(s).

CONFIDENTIALITY DISCLOSURE

Staff and contracted service providers, such as home providers, will keep confidential all information about individuals served at the Community Access Program and other members of the Community Access Program community.

Program staff, contracted service providers and volunteers will adhere to the Community Access Program Confidentiality Policy as follows:

As a contracted service provider for the Community Access Program, I understand that I may have access to reports and/or information concerning individuals served, personnel and financial information, either in electronic or paper form, that must remain confidential. I will take reasonable and prudent measures to ensure the confidentiality of information I have by:

- Discussing or otherwise disclosing information only to those authorized to receive such information, i.e. service coordinator, agency staff involved with the care of the individual in my home, guardian, medical providers or other third parties for whom a signed Release of Information Form exists with the Community Access Program.
- Storing records and reports in a manner that prevents accidental discovery or easy access to written documents, i.e. copies are covered and stored in a drawer or other manner that would prevent accidental discovery.

I understand that failing to take measures to ensure confidentiality of reports and/or information may result in actions, up to and including termination of my contract with the Community Access Program.

Upon conclusion of my work with the Community Access Program, I understand that I must return all reports and copies that I obtained in my responsibilities with the Community Access Program and that I must hold confidential all information contained in the reports to which I had access.

EMPLOYMENT STATUS DISCLOSURE

Entering into a contract as a Shared Living/Home Provider, if established pursuant to this application, does not constitute employee status with the Community Access Program. Rather, the eligible provider shall be considered an independent contractor. Compensation to the provider shall be determined by funds and/or third party funding source, and shall be based upon an individual's eligibility and need for services.

Please keep this page for your records.