

PRIOR WORK EXPERIENCE

<u>COMPANY NAME</u>	<u>ADDRESS</u>	<u>SUPERVISOR</u>	<u>POSITION</u>	<u>PHONE NUMBER</u>

PERSONAL REFERENCES

<u>NAME</u>	<u>ADDRESS</u>	<u>PHONE NUMBER</u>

PROVIDER QUALIFICATION:

PLEASE LIST ANY SPECIAL TRAINING, SKILLS, OR CERTIFICATIONS YOU HOLD THAT WOULD PERTAIN TO THE POSITION YOU ARE APPLYING FOR BELOW:

Have you ever been convicted of a felony involving forgery, robbery, larceny, fraud, cruelty to persons, sexual assault, assault, assault of an elderly, blind, disabled, pregnant or mentally retarded person or abuse of the elderly, blind, disabled or mentally retarded person in the United States and/or it's territories? Yes No

LANGUAGES SPOKEN (CHECK THOSE THAT APPLY):

ENGLISH SPANISH OTHER (LIST): _____

Are you currently a provider on the ABI Medicaid Waiver Program (check one): Yes No

If you checked no, would you like information to be sent to you regarding this program (check one): Yes No

*The ABI Medicaid Waiver Program is a home & community based program for those individuals who have sustained an acquired brain injury and allows the individual to live in their home or community with supports. Providers for this program are needed in all areas of the State. Individuals whom are listed on the directory for this program may receive telephone calls from the participants on the program, their DSS social worker, conservator, or family representative looking for individuals to provide services to them.

Please check here if you are currently employed by another individual on the P.C.A. Waiver, ABI Waiver, or ElderCare Pilot Programs:

By signing and dating below, I understand that a Criminal Background check will be performed prior to being hired by an individual on the PCA Waiver Program or at the request of my potential employer. I also authorize full release of information from my listed employers and references.

Provider Name: *(please print)* _____

Provider Signature: _____ Date Signed: _____