ENROLLMENT REQUEST FOR RESPITE TRAINING

Providers Name: _____ **Are you 18 or older?** Yes / No ~ **Sex:** M/ F
Last Mi First

Residence: _____
Street Address

_____ County: _____
Town/City State Zip

Phone: (home) _____ (Contact/Cell) _____

Email Address 1: _____ Email Address 2: _____

Do you have the legal right to accept employment in the United States? ☐ YES ☐ NO

Have you ever been convicted of a felony or misdemeanor crime that has not been annulled by a court?

☐ YES ☐ NO

If you answered Yes, you must provide the dates, location, and nature of the felony or misdemeanor conviction.

_____

IF YOU LEAVE THIS SPACE BLANK, YOU ARE CERTIFYING THAT YOU HAVE NO CURRENT RECORD OF CONVICTION. Please note: conviction is not an automatic disqualifier for enrollment, but may require a waiver for continued employment. Willful omission or misrepresentation of required information will be a basis for rejection of your enrollment application. Families you provide services for may contact the Lifespan Respite Coalition to get details of any convictions found.

Do you have experience in providing respite services? ☐ YES ☐ NO

If YES, is there someone/someplace who we can contact about these services?

_____

Contacts Name: _____ Phone Number: _____

Availability to Work:

How many miles from your home are you able to regularly travel? (Choose the furthest distance) _____5-10

_____10-15 _____15-20 _____20-25 _____25-30 _____Any Distance

What age groups are you most comfortable working with? (Choose all that apply) _____Infant (0-1)

_____Toddler (1-5) _____Youth (5-10) _____Teen (13-17)_____ Adult (18+) _____Senior (65+)

Which type of population groups are you willing to or have you provided care for?
Those with: (Choose all that apply)

☐ Physical Disabilities	☐ Emotional /Behavioral Disabilities	☐ Learning/Developmental Delays
☐ Social Disabilities	☐ Other Cognitive Disabilities	☐ Other _____

Created: April 13, 2010

Which Chronic Illnesses do you know about or have experience providing care for? (Check all that apply)

- ☐ Alzheimer's/ Dementia (AD)
- ☐ Asthma / Allergies
- ☐ Attention Deficit Disorder (ADD/ADHD)
- ☐ Autism /PDD/Aspergers'
- ☐ Cancer (Active / Remittance)
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Developmental Disabilities
- ☐ Diabetes Type I / II – Insulin Dependent
- ☐ Emotional/ Mental Health Problem
- ☐ Hemophilia/Blood Disorders
- ☐ Metabolic Disorder /PKU
- ☐ Muscular Dystrophy
- ☐ Seizure Disorder/Epilepsy
- ☐ Severe Emotional Disturbances (SED)
- ☐ Spina Bifida
- ☐ Spinal Cord Injury/ Plegia
- ☐ TBI (Traumatic Brain Injury)
- ☐ Other:_____
- ☐ Other:_____

Personal Experience or Training you have. (Check off and date all that apply)

- ☐ Alzheimer Training ____/____
- ☐ Autism Training ____/____
- ☐ Baby Sitting
- ☐ Basic First Aid ____/____
- ☐ CPR ____/____
- ☐ Red Cross Training ____/____
- ☐ Seizure Training ____/____
- ☐ Foster Parent Training ____/____
- ☐ Sibling or Family Member
- ☐ OTHER_____

Additional Factors:

Preferences:

- ☐ Pets Are OK (Dog/Cat/Bird/Snake etc.)
- ☐ Need Smoke Free environment
- ☐ Can Provide My Own Transportation
- ☐ Can Lift Minimum of 50 pounds

Willing To:

- ☐ Provide for More Than One Child at a time
- ☐ Transport Child in own car
- ☐ Cook/Prepare Meals
- ☐ Provide Personal Care/ADL's

Availability for Respite Care:
(Check all days and times that you will be available)

Day of Week	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
Early Morning (6-9am)	☐	☐	☐	☐	☐	☐	☐
Late Morning (9-12 pm)	☐	☐	☐	☐	☐	☐	☐
Early Afternoon (12-3pm)	☐	☐	☐	☐	☐	☐	☐
Late Afternoon (3-6 pm)	☐	☐	☐	☐	☐	☐	☐
Early Evening (6-9pm)	☐	☐	☐	☐	☐	☐	☐
Late Evening (9-12am)	☐	☐	☐	☐	☐	☐	☐
Overnight (12am-6am)	☐	☐	☐	☐	☐	☐	☐

Amount of Notice Needed to Provide Services:

Request By: _____Phone _____E-mail (as listed)

Request Time Required: _____24 Hours _____48 Hours_____Specify number of Days

Your response to a request to provide services can be expected within _____hours or _____days

by_____(method)

Your Requested Hourly Rate: (Please enter exact amount with in the range that you are requesting)

_____$7.25-10.00 _____$10.00-15.00 _____$15.00-20.00 _____other amount

LICENSE AND CERTIFICATION (RN, LPN, CNA ETC.)

Please list any license or special certification that you hold, specifying license/certificate number and date of expiration:

Driver's License #		Class		Expires			Other		Expires	
Other:				Expires			Other		Expires	

CREDIT FOR CERTIFICATION THROUGH TRAINING OR EXAMINATION

If you have completed approved coursework and have achieved special certification through training or examination, you must submit proof of course completion and the certificate earned.

(Title Or Certificate Earned)	*(Date Certificate Earned)*	*(Certifying State, Agency Or Organization)*
(Title Or Certificate Earned)	*(Date Certificate Earned)*	*(Certifying State, Agency Or Organization)*

Additional Languages Spoken: _____

Please tell us a little bit about yourself, your personal experience and why you want to enroll as a respite provider.

_____

_____

_____

_____

_____

I UNDERSTAND THAT IN ORDER FOR MY APPLICATION OF ENROLLMENT TO BE CONSIDERED, THE AFFIRMATION BELOW MUST BE COMPLETED.

I CERTIFY THE INFORMATION PROVIDED IN OR ATTACHED TO THIS APPLICATION IS COMPLETE, ACCURATE AND UP-TO-DATE. I FURTHER CERTIFY THAT THERE ARE NO WILLFUL MISREPRESENTATIONS OF THE ABOVE STATEMENT AND THE ANSWER TO THE QUESTIONS HEREIN AND THAT, I HAVE MADE NO OMISSIONS OF MATERIAL FACT WITH RESPECT TO ANY OF MY ANSWERS TO THE QUESTIONS PRESENTED. I UNDERSTAND THAT I MAY BE SUBJECT TO A BACKGROUND INVESTIGATION; AND IF SUCH INVESTIGATION SHOULD DISCLOSE SUCH MISREPRESENTATIONS OR OMISSIONS, MY APPLICATION MAY BE REJECTED.

SIGNATURE OF APPLICANT: _____ DATE SIGNED: _____

Printed name of applicant: _____

Mail completed application to: DHHS /Special Medical Services, 129 Pleasant Street , Thayer Bldg, Concord NH 03301

OPTIONAL CONSENTS

I hereby consent to the submission of my name for review against the Department of Health and Human Services registry of founded reports of abuse, neglect or exploitation and Criminal Background

_____ (Signature of applicant)

I further consent to the release of any information about any founded report to my current employer or prospective employer*.* _____ (Signature of applicant)

***Is the family whom respite will be provided and at the request of the family.**