



A-1 Community Choice LLC
"Where Individuals Come First"

Notice:

This is the short version of our application packet. If you are interested in applying as a caregiver at A-1 Community Choice please fill out this packet and return it to the office. This packet can be emailed to a1communitychoice@hotmail.com or faxed and signed electronically at time of interview or you can mail or hand deliver it to the office. You would be required to fulfill all requirements listed at a1communitychoice.com in accordance with APD's iBudget handbook. We suggest that you call the office and discuss all of this information before completing the education requirements. Please remember that simply completing the education requirements and applying does not guarantee a position.

If hired you will be required to pay for your Level 2 background screening and CPR/First Aid training. If you have any questions feel free to contact us.



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PERSONNEL INFORMATION

Name _____
(First) (Middle Initial) (Last)

D.O.B. _____ M _____ F _____

Address _____
(Address) (City) (State) (Zip)

Education Level: _____

Home Phone (_____) _____ S.S.N _____

Cell Phone:(_____) _____ E-Mail Address _____

Emergency Contact: _____ Relationship _____

Phone (_____) _____

EMPLOYER USE ONLY

<u>Section I Personnel Info.</u>	<u>Section II</u>	<u>Section IV</u>
1.Driver's License	Privacy Policy Acknowledgement Form	Zero Tolerance* <i>Before working with client</i>
	DCF Clearing House Screening	Direct Care Core Competencies (DCCC)* <i>30 days after hire</i>
2.Personnel Information	FDLE Screening/Rap sheet	HIPAA* <i>30 days after hire</i>
Requirements for Service Provider	Local Law Screening	CPR Certification **
Application	Affidavit of Compliance	1 st Aid Training **
Reference - Work	Attestation of GMC	Blood-Borne Pathogens **
Reference -Personal	<u>Section III</u>	<i>60 days after hire</i>
Employee 90 Day Letter	W4 Form	Requirements for all Waiver Providers
Handbook Acknowledgement	Paychex Direct Deposit	
Pre-Employment Test Consent	Voided Check/Bank letter	
Drug Free Signature Page		Annual In-Service Training
High school Diploma/GED	<u>I-9 BOOK</u>	iConnect ID Proofing- Office
	I-9 (DHS Form)	
3. Vehicle Registration	Drivers License	Hire Date:
Vehicle insurance	Social or Birth Cert.	Termination Date:

*Online Courses

**If you need CPR, 1st Aid and BBP please let the office know so we can email you contact information.



Care Provider Background Screening Clearinghouse Background Screening Request Form

You have applied for a position with a health care and/or service provider regulated by a specified agency in the Care Provider Background Screening Clearinghouse (Clearinghouse) that requires a fingerprint-based background check. As a health care and/or service provider regulated by a specified agency in the Clearinghouse we may conduct a search for an existing background screening result or submit a new background screening request through the Clearinghouse results website on your behalf.

In order to complete the search and/or background screening request we must collect the following information. This information is required by the Clearinghouse, the Florida Department of Law Enforcement, and the Federal Bureau of Investigation.

Please provide the following information:

Applicant Information

*First Name: _____
Middle Name: _____
*Last Name: _____
Aliases: _____
*SSN: _____
*Date of Birth: _____
*Place of Birth: _____

Demographics

*Sex: _____
*Race: _____
*Hair Color: _____
*Eye Color: _____
*Height: _____
*Weight: _____

Contact Information

*Address Line 1: _____
Address Line 2: _____
*City: _____
*State: _____
*Zip: _____
County _____
Prior States last 5 years: _____
Email: _____
Phone: _____

*Denotes Required Fields



PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

Employee/Contractor Name (Printed)

Employee/Contractor Signature

Date



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Requirements for Service Provider

SUMMARY: Direct Service Provider may provide one or more of the following services: Personal Supports, Life Skills I, Supported Living or Respite

GENERAL QUALIFICATIONS:

Must be at least 18 years of age or older.

Must complete a Level II Screening in accordance with Sections 435.04 Florida Statutes

Copies of valid Florida driver's license, vehicle registration, vehicle insurance

Must be eligible to complete an I-9 Form

Affidavit of Good Moral Character signed and notarized

Must comply with the agency's drug free work place policy

Must have own, dependable transportation to and from the job site.

QUALIFICATION REQUIREMENTS:

To perform services successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION AND/OR EXPERIENCE:

High School diploma or equivalent

Certification in CPR, First Aid and Bloodborne Pathogens Required within 30 days

Must complete Program Specific training; Introduction to Developmental Disabilities, Health and Safety, and Zero Tolerance

Must have at least one year of verifiable experience working directly with individuals receiving services in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability.

LANGUAGE:

Must have the ability to communicate effectively verbally and in writing

Demonstrate active listening: listening to what other people are saying and asking questions as appropriate.

REASONING ABILITY:

Ability to solve practical problems and deal with various situations

Ability to interpret instructions in written, oral, or schedule form

Ability to establish effective working relationships with family members and the special needs of the individual being served

Time Management: the ability to manage one's own time to both arrive at assignment in a timely manner as scheduled as well as to be able to complete assigned tasks in the time allotted.

Documentation: Service Logs must include proper recording of services performed as well as accurate completion of other applicable forms (incident reports, etc.)

PHYSICAL NEEDS:

The physical demands described below are representative of those that must be met by a service provider to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individual with disabilities to perform the essential functions. While performing the duties of this service, the service provider is sometimes required to stand, walk, use hands and fingers to handle objects, tools, or controls, reach with hands and arms, bend and stoop, talk, and hear. Additionally, the service provider may be required to engage in physical activities that require whole body range of motion such as climbing stairs, walking, stooping, lifting and balancing. The service provider is frequently required to visually discriminate between small objects. The service provider will often lift or move up to 25 pounds; frequently lift 25 - 50 pounds and on occasion may need to maneuver weights in excess of 50 pounds through transfers and other job related activities.

The service provider must be able to redirect the individual being served if that individual is in danger of hurting him/herself or others. Some outdoor play activities may be requested. The service provider must be able to work night, weekend and/or holiday hours as necessary.

Service Provider Signature _____ Date _____



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Application for Employment

Our policy is to provide equal employment opportunity to all qualified persons without regard to race, creed, color, religious belief, sex, age, national origin, ancestry, physical or mental disability, or veteran status.

First name _____ Last name _____ Date _____

Education School Name and Location Year Major Degree

High School _____

College _____

Other Training _____

Employment History (Start with most recent employer) or attach resume

Company Name _____

Address _____ Telephone _____

Date Started _____ Starting Wage _____ Starting Position _____

Date Ended _____ Ending Wage _____ Ending Position _____

Name of Supervisor _____

Reason for leaving _____

May we contact? Yes No

Responsibilities _____

Reason for leaving _____

Company Name _____

Address _____ Telephone _____

Date Started _____ Starting Wage _____ Starting Position _____

Date Ended _____ Ending Wage _____ Ending Position _____

Name of Supervisor _____

May we contact? Yes No

Responsibilities _____

Reason for leaving _____

1551 Garden St.
Titusville, FL 32796
Phone 321-269-8563
Fax 321-267-5708
a1communitychoice@hotmail.com



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Are you a U.S. citizen or otherwise authorized to work in the U.S. on an unrestricted basis? (You may be required to provide documentation.) Yes No

Have you ever been convicted of a felony? (This will not necessarily affect your application.) Yes No

If yes, please describe conditions. _____

Employment Application

Attach additional information if necessary.

I certify that the facts set forth in this application for employment are true and complete to the best of my knowledge. I understand that if I am employed, false statements on this application shall be considered sufficient cause for dismissal. This company is hereby authorized to make any investigations of my prior educational and employment history.

I understand that employment at this company is "at will," which means that either I or this company can terminate the employment relationship at any time, with or without prior notice, and for any reason not prohibited by statute. All employment is continued on that basis. I understand that no one, other than the manager/ owner, has any authority to alter the foregoing.

Signature _____ Date _____



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Personal Reference

CONFIDENTIAL REFERENCE REQUEST

Applicant Name: _____ Date: _____

Personal Reference Name: _____

Phone #: _____ Fax#: _____

Relationship with personal reference: _____ Known how long: _____

I, _____ have applied to A-1 Community Choice for contractual employment. I hereby release from all liability the person completing this form, and authorize them to release all information regarding my relationship with them.

Applicant's Signature: _____ Date: _____

*****This section to be filled out by personal reference*****

A1 Community Choice conducts a complete reference check, prior to contracting, on each applicant. All information supplied by you is confidential. Any statements that you wish to make in the Additional Comments section would help us determine a placement for this applicant.

Is the above information correct? Yes No In not, explain: _____

Is this applicant dependable and on time? Yes No

Is there any reason you feel this applicant should not provide services to an individual with a developmental disability? Yes No If yes, explain: _____

Additional comments: _____

Printed Name: _____ Title: _____ Date: _____

Signature from Personal Reference: _____

Please Fax this completed form to 1 (321) 267-5708 or return by e-mail or mail.

Thank you for taking the time to complete this reference.

Phone 321-269-8563
Fax 321-267-5708
a1communitychoice@hotmail.com



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Work Reference

CONFIDENTIAL REFERENCE REQUEST

Applicant Name: _____ Date: _____

Previous Employer: _____

Phone #: _____ Fax#: _____

Employed From: _____ To: _____ Position held: _____

I, _____ have applied to A-1 Community Choice LLC for contractual employment. I hereby release from all liability the company and/or person completing this form, and authorize them to release all information regarding my employment with them.

Applicant's Signature: _____ Date: _____

*****This section to be filled out by previous employer*****

A1 Community Choice LLC conducts a complete reference check, prior to contracting, on each applicant. All information supplied by you is confidential. Any statements that you wish to make in the Additional Comments section would help us determine a placement for this applicant.

Is the above information correct? Yes No If not, explain: _____

Is this applicant dependable and on time? Yes No

Is there any reason you feel this applicant should not provide services to an individual with a developmental disability? Yes No If yes, explain: _____

Did/does this applicant provide quality care? Yes No If not, explain: _____

Is this applicant eligible for rehire? Yes No If not, explain: _____

Additional comments: _____

Printed Name: _____ Title: _____ Date: _____

Signature from previous employer: _____

Please Fax this completed form to 1 (321) 267-5708 or return by mail.

Thank you for taking the time to complete this reference.

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PRE-EMPLOYMENT DRUG TESTING CONSENT AND RELEASE FORM

I hereby consent to submit to the testing for drugs and/or alcohol as shall be determined by A-1 Community Choice LLC in the selection process of applicants for employment.

I agree that (Name of clinic or physician) Quest Diagnostics

May collect specimens for these tests and may test them, if qualified, or forward them to a licensed or certified laboratory designated by the company for analysis. I further agree to and hereby authorize the release of said test results to the company.

I understand that current use of illegal drugs may prohibit me from being employed at A-1 Community Choice LLC.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I carefully read the foregoing and fully understand its contents. I acknowledge that signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

Applicant:

Print Name	
Signature	
Date Of Birth	
Phone Number	
Date	

Phone 321-269-8563
Fax 321-267-5708
a1communitychoice@hotmail.com



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Employee Availability

Please fill in the hours you are available to work.

**Employee
Name:**

Saturday:

Sunday:

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Additional comments: _____

Please Fax this completed form to (321) 267-5708 or return by mail or email.

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