Advocacy Partners, LLC

Service…Commitment, Support, Dreams
3150 Carlisle NE, Suite 201
Albuquerque, NM 87110
P: (505) 872-2115, F: (505) 872-9490

Initial Request for New Provider

All of the following documents must be current

- ☐ Copy of Current Driver's License
- ☐ Copy of Social Security Card
- ☐ Copy of Vehicle Registration
- ☐ Copy of Vehicle Insurance
- ☐ Copy of any Training Certificates *(Especially CPR/First Aid)*
- ☐ Copy of Homeowners/ Renters Insurance *(Only if applying for FLP/CHIS)*
- ☐ Copy of Animal Vaccinations *(Only if applying for FLP/CHIS)*
- ☐ Certificate of Health *(Only if applying for FLP/CHIS)*

As a new provider, you will need to have your fingerprints taken and have a federal and statewide background check completed. For more information or to make an appointment please call our office.

Venessa Rael,

Records Department Manager
Training Coordinator

Advocacy Partners, LLC

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APPLICATION INFORMATION

Position Applying for *(Check all that applies):*

FLP/ CHIS	Substitute Care	CCS	Respite	Office Employee

__________________________ __________________________ __________________________

First Name Full Middle Name Last Name

Address: __________________________________ City/State/ Zip: _________________________

Social Security No. ____________________________Date of Birth: ________________________

E-Mail: ____

Cell Phone: ________________ Home Phone: ________________ Work Phone: _______________

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____________________________________ Relationship: __________________________
Phone#: ______________________ Address: ____

OTHERS RESIDING IN HOME

If anyone in the household 18 years of age or older must complete criminal history-screening
(Only complete if applying for FLP/CHIS)

Name	Relation	DOB

RECORD OF EDUCATION

(Include High School, University/ College, Trade, Business or Correspondence School)

School Name & Address	Course of Study	Years Completed	Did you Graduate?	Diploma/ Degree
Name: Address: City, State:		To: From:	Yes ______ No ______	
Name: Address: City, State:		To: From:	Yes ______ No ______	
Name: Address: City, State:		To: From:	Yes ______ No ______	

EMPLOYMENT HISTORY

All employers listed below will be requested to verify the information that you provide herein

Employer Name: ____ Phone # _________________
Address: __________________________________ City/State/Zip ________________________
Date of Employment (month/year): ____________ to ____________ Salary: ________________
Position Held: ____________________________ Supervisor: ____________________________
Job Duties: ____
Reason for Leaving: ____

Employer Name: ____ Phone # _________________
Address: __________________________________ City/State/Zip ________________________
Date of Employment (month/year): ____________ to ____________ Salary: ________________
Position Held: ____________________________ Supervisor: ____________________________
Job Duties: ____
Reason for Leaving: ____

Employer Name: ____ Phone # _________________
Address: __________________________________ City/State/Zip ________________________
Date of Employment (month/year): ____________ to ____________ Salary: ________________
Position Held: ____________________________ Supervisor: ____________________________
Job Duties: ____
Reason for Leaving: ____

(I hereby authorize Advocacy Partners to contact the above listed employers to obtain information concerning my past employment history.)

____ ________________________________
Signature Date

MILITARY SERVICE RECORD

US Military Service: _____________________________________ Rank: ________________
Date of Service: ________________________ Honorable Discharge? Yes:______ No: ______
National Guard or Reserves: __________________________ Date of Service: ______________
Honorable Discharge? Yes: ______ No: ______

CHARACTER REFERENCES

List three people; exclude relatives, whom we can contact by mail, telephone or in person to provide a character reference for you. Please list complete address.

Name	Years Know	Address	Phone#
			Day# Evening #
			Day# Evening #
			Day# Evening #

(I hereby authorize Advocacy Partners to contact the above listed individuals to obtain my personal and professional history for purpose of this pre-screening.)

____ ______________________________
Signature Date

CRIMINAL HISTORY

Have you ever been named in a complaint, arrested or received a felony conviction?
YES: _____________ NO: _____________

(I hereby authorize Advocacy Partners to obtain information concerning my past criminal history for the purpose of this pre-screening.)

____ ______________________________
Signature Date

(Past criminal history may disqualify you from providing services (29NMAC 17.2, New Mexico's Caregivers Criminal History Screening Act. If you checked YES above, please enclose documentation about each situation. The CCHSP, DOH has the final authority to qualify or disqualify caregivers. If you disagree with their decision you may request a reconsideration by calling 1-505-827-1417.)

CITIZENSHIP

Are you a United States Citizen? ____ Yes ____ No OR
Are you a Legal Resident? ____ Yes ____ No
(Please enclose a copy of your Social Security Card or "Green" card.)

HEALTH

Do you have a medical condition, mental illness or disability that would prevent you from providing support services to a person with disabilities? _____ Yes _____ No

____ ______________________________
Signature Date

DRIVER INFORMATION

Do you have a valid driver's license? _____ Yes _____ No
License No. ____________________________ State: ________ Expiration Date: __________

(I hereby authorize Advocacy Partners to obtain information concerning my past driving history for the purpose of this pre-screening.)

____ ______________________________
Signature Date
(Please enclose a copy of your driver's license. A copy of your driving record will be requested.)

VEHICLE INFORMATION

Main vehicle that will be used to transport the person receiving services:
Year: ________________ Make: ______________________ Model: ____________________
License No. ________________ Vehicle Identification No. _____________________________
Name of Registered Owner(s): ____
Insurance Company: ____
Secondary vehicle that will be used to transport the person receiving services:
Year: ________________ Make: ______________________ Model: ____________________
License No. ________________ Vehicle Identification No. _____________________________
Name of Registered Owner(s): ____
Insurance Company: ____
(Please enclose copies of your vehicle registration and proof of car insurance.)

Please circle YES or NO to the questions

Are you willing to provide Respite/ Substitute Care in your home?	YES	NO
If so, are you willing to have individual's sleep over?	YES	NO
Would this individual have their own room where they could have privacy and their things would be safe?	YES	NO
Do you have pets? If yes please list type(s):	YES	NO
Are you willing to stay over at the individual's home?	YES	NO
Would you be willing to take individual's to church of their choice, even if it is not your faith or belief?	YES	NO
Would you be willing to take two individual adults out on a date, if that is what they wanted to do?	YES	NO
Are you able to provide emergency respite or sub-care? *This might be respite/sub-care for some that you do not necessarily know but will be crossed trained on.*	YES	NO
Are you interested in being a back-up respite or sub-care provider?	YES	NO
Are you interested in being a back-up CCSI/ CCSSG provider?	YES	NO
Are you willing to work with an individual with mobility issues, such as using wheelchairs, walkers, etc?	YES	NO
Are you able to assist an individual with transferring to and from a wheelchair?	YES	NO
Is your home wheelchair accessible?	YES	NO
Do you have a vehicle that has a wheelchair lift or is wheelchair accessible?	YES	NO
Are you willing to work with an individual that is hearing, communicatively and/or visually impaired?	YES	NO
Do you know sign language?	YES	NO
Are you bi-lingual? If yes, please list what language(s):	YES	NO
Would you be willing to provide transportation for our individuals?	YES	NO
Is your vehicle dependable to transport individuals?	YES	NO
Do you have any individuals living in your home now? Male or Female?	YES	NO
Are you able to complete all trainings?	YES	NO
Are you to lift at least 40 lbs?	YES	NO

ADULT CHILDREN OR ADULT RELATIVE

List all adult children living (or out of) in your home, or at least one adult relative not living in your home. *(Only complete if applying for FLP/CHIS.)*

Name	Do they live with you?	Address	Phone#
	Yes _____ No _____		
	Yes _____ No _____		
	Yes _____ No _____		

AVAILABLE

DAYS	HOURS
Monday ☐	Day (From: To:) Night (From: To:)
Tuesday ☐	Day (From: To:) Night (From: To:)
Wednesday ☐	Day (From: To:) Night (From: To:)
Thursday ☐	Day (From: To:) Night (From: To:)
Friday ☐	Day (From: To:) Night (From: To:)
Saturday ☐	Day (From: To:) Night (From: To:)
Sunday ☐	Day (From: To:) Night (From: To:)

APPLICANT'S PERSONAL CERTIFICATION

I hereby certify that all of the information submitted by me on this application and any additional information that I have submitted to Advocacy Partners LLC. during this pre-screening process is true and complete. I understand that if any false information, omissions, or misrepresentations are discovered, I may be disqualified from continuing in the application process or, in the event I have entered into a contract or employment to provide services to Advocacy Partners LLC. my contract or employment will be terminated.

____ _____________________

Applicant's Signature Date

APPLICANT'S
AUTHORIZATION TO RELEASE INFORMATION

I understand that the Long Term Services Division, Department of Health, has set certain policies pertaining to the home study process intended to assure that individuals receiving services live in settings with others who promote the individual's capacity for independent functioning and productivity and in which the individual's health and safety is assured. Therefore, I hereby authorize Advocacy Partners LLC. to request the following background information concerning me and authorize the following named entities or person to release such information to Advocacy Partners LLC.

1) An FBI background and fingerprints check from the New Mexico Department of Health Caregivers Criminal History Screening Program.
2) Any New Mexico arrest fingerprints card supported record information maintained by the New Mexico Department of Public Safety (or similar agencies in other states where I have resided within the past years), including information concerning felony or misdemeanor arrests (an Authorization for Information is enclosed);
3) A driver's record check based upon my driving record maintained by the New Mexico Motor Vehicle Department (or similar agencies in other states where I have resided within the past years);
4) Information about my personal and professional history provided by the person whose names and addresses I have listed above as character references or any former employers I have listed above;
5) My medical record information provided my healthcare provider; and
6) Information provided by my adult children and/or at least one adult relative whose names and addresses I have listed in this application.

I understand that Advocacy Partners LLC. will not use any of the information above for any other purpose other than pre-screening and will comply with all provisions of the Fair Credit Reporting Act, Public Law 91-508, and the Americans with Disabilities Act (ADA 1990), and all other applicable Federal and State laws and regulations. All information obtained is for the exclusive use of Advocacy Partners except to disclose said information to me and in accordance with applicable law and the provisions and policies of the Medical Assistance Division of New Mexico Human Services Department, Medical Assistance Program Manual, Section MAD-736, and the contract between Advocacy Partners and the Long Term Services Division of the New Mexico Department of Health.

____ ____________________

Applicant's Signature Date

Advocacy Partners LLC.

FIREARMS AGREEMENT

I understand that the Long Term Services Division, Department of Health, has set certain policies pertaining to the home study process intended to assure that individuals receiving services live in settings that are safe. I understand that the acceptable means of securing weapons and ammunition are either with trigger locks or in locked closets, cabinets or drawers that are sturdy enough to resist a child or young adult's efforts to open. I understand that storage units and locks should be checked periodically to ensure that they are still secure and/or have not been tampered with. I further understand that ammunition should be stored further than arm's length from the weapon in a separate locked container.

I hereby certify that, to prevent injury or death from accidental shooting, all firearms and weapons, including, but not limited to, handguns, rifles and shotguns, bows and arrows, and pellet guns will be secured under lock and key at all times. All forms of ammunition will be stored separate from the weapons in a locked container that is located further than arm's length from the weapon.

I understand and accept the responsibility that any failure to comply with firearm safety requirements may result in a termination of the contract with Advocacy Partners LLC. signed by either me or a member of my household. My signature below indicates that I understand and agree to comply with these firearm safety requirements.

Signature: ____

Please Print Name: ____ Date: _______________

Your Email Address: _______________________________ Phone: _(_____)______________

Name of Agency: ____

Signatures of Other Adults in the Household: ____

______________________________________   ____________________________________

Agency Signature: ____

Please Print Name: _____________________________________ Date: __________________

ATTENTION!

AWMD and Incident Reporting (ANE) is only good for <u>ONE YEAR and is Agency Specific Trainings</u> and First Aid & CPR is good for only <u>TWO YEARS!</u>

DDSD Pre-Service, Orientation, and Level One Competency Requirements for Direct Support Staff and Their Supervisors

Pre-Service Level - This level must be completed within 30 days. Refresher courses are recommended every few years to ensure that staff members are familiar with the ongoing initiatives of the Division.

- **Pre-Service**
- **Foundation for Health and Wellness (Classroom and Online Hybrid version available)**
  **Note: This course replaces the Basic and Orientation Health. The Online Hybrid version will be available statewide in Fall 2010.*
- **Individual-Specific Training (formerly "Addendum B")**
  **Note: This training is not a specific course – it is on-the-job training per methodologies stated in each individual's ISP. Each individual ISP will determine the timeframe for completion of this training. Specific courses (e.g., MANDT, AWMD, Sexuality for People with Developmental Disabilities) may be required as part of the Individual-Specific Training requirements.*

Orientation Level – This level must be completed within 90 days. Re-certification is required for Assisting with Medication Delivery. Refresher courses of other orientation level courses are recommended every few years to ensure that staff members are familiar with the ongoing initiatives of the Division.

- **Person-Centered Planning in New Mexico (One-Day)**
  **Note: This course replaces the Individual Service Planning in NM (One-Day). Direct support staff and direct support staff supervisors who previously completed Individual Service Planning in NM (One-Day) are not required to complete this course.*
- **Assisting with Medication Delivery**
  **Notes: 1) This course is only required for specific staff members who assist with medication delivery. 2) This course must be completed prior to any staff member assisting with medication delivery. 3) This course replaces AWM and TSAM. Staff members who previously completed AWM or TSAM must be re-trained in this new course. 4) Staff members who assist with medication delivery must complete an annual recertification requirement of this course.*

Level One – This level must be completed within the first year. Refresher courses are recommended every few years to ensure that staff members are familiar with ongoing initiatives of the Division.

- **Participatory Communication and Choice-Making**
- **Advocacy 101**
  **Note: This course no longer meets training requirements for case managers and service coordinators.*
- **Supporting People with Challenging Behaviors OR Positive Behavior Support Strategies**
  **Note: The Supporting People with Challenging Behaviors course is designed exclusively for direct support staff and their supervisors. Positive Behavior Support Strategies is a newer course that addresses competency requirements for case managers, service coordinators, direct support staff and direct support staff supervisors.*
- **Teaching and Support Strategies**
  **Note: This course replaces and meets the requirements previously addressed by Vision to Action: Goals, Objectives, and Strategies. Direct support staff and direct support supervisors who have completed Vision to Action: Goals, Objectives, and Strategies do not need to complete this course.*

Note: Additional training requirements are documented in the DDSD Policy "Training Requirements for Direct Service Agency Staff." These trainings include (but are not limited to) the following: applicable OSHA training requirements (ongoing certification in ***First Aid and CPR****, standard/universal precautions, and hazard communications), additional DOH training requirements (yearly training on abuse, neglect, and exploitation; MANDT/CPI/Handle with Care), and any applicable requirements stipulated by other state and federal agencies (e.g., Department of Transportation requirements for Defensive Driving).*