Advocacy Partners, LLC

Date Received application: _____

Service…Commitment, Support, Dreams

3150 Carlisle NE, Suite 201
Albuquerque, NM 87110
Phone: (505) 872-2115, Fax: (505) 872-9490

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
The office at (505) (505) 872-2115.

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: _____

E-Mail: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____
Phone#: _____ Address: _____

OTHERS RESIDING IN HOME (For Family Living Providers only)

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 _____	

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: _____

(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.)

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

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:)

_____ _____

Signature Date

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: _____
(Please enclose copies of your vehicle registration and proof of car insurance.)

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

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 training?	YES	NO
Are you to lift at least 40 lbs.?	YES	NO

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 are assured. Therefore, I hereby authorize Advocacy Partners LLC. to request the following background information concerning me and authorize the following named entities or persons 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 was 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, 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 separately 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.

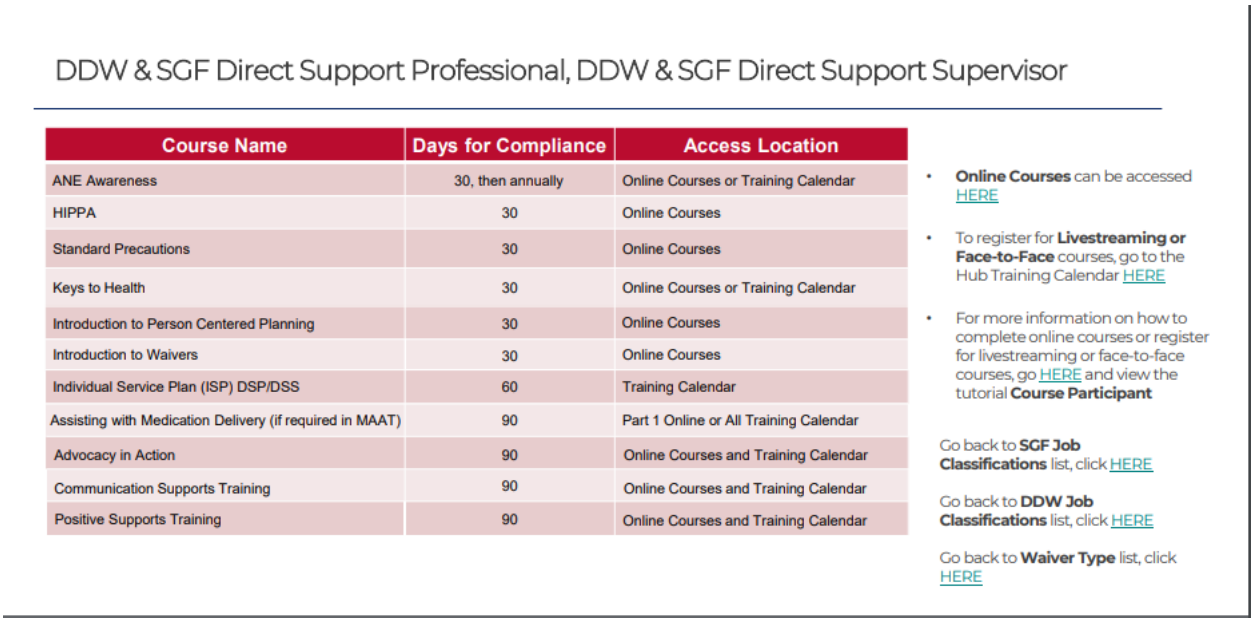
Signature: _____

Please Print Name: _____ Date: _____

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

Name of Agency: _____

Classes required



DDW & SGF Direct Support Professional, DDW & SGF Direct Support Supervisor

Course Name	Days for Compliance	Access Location
ANE Awareness	30, then annually	Online Courses or Training Calendar
HIPPA	30	Online Courses
Standard Precautions	30	Online Courses
Keys to Health	30	Online Courses or Training Calendar
Introduction to Person Centered Planning	30	Online Courses
Introduction to Waivers	30	Online Courses
Individual Service Plan (ISP) DSP/DSS	60	Training Calendar
Assisting with Medication Delivery (if required in MAAT)	90	Part 1 Online or All Training Calendar
Advocacy in Action	90	Online Courses and Training Calendar
Communication Supports Training	90	Online Courses and Training Calendar
Positive Supports Training	90	Online Courses and Training Calendar

- **Online Courses** can be accessed HERE
- To register for **Livestreaming or Face-to-Face** courses, go to the Hub Training Calendar HERE
- For more information on how to complete online courses or register for livestreaming or face-to-face courses, go HERE and view the tutorial **Course Participant**

Go back to **SGF Job Classifications** list, click HERE

Go back to **DDW Job Classifications** list, click HERE

Go back to **Waiver Type** list, click HERE

- **AWMD (This class will need to be taken annually)**
- **Incident Reporting (ANE) (This class will need to be taken annually)**
- **First Aid & CPR is good for only TWO YEARS!**