Community Treatment Solutions

Application To Serve As A Treatment Home Provider

It is our policy not to discriminate on the basis of race, religion, color, creed, ancestry, national origin, sex, sexual orientation, age, veterans status or disability which does not interfere with the ability to perform the essential functions of a vendor of home services.

PERSONAL INFORMATION

Name ____
Last *First* *Middle*

Social Security ____

Present Address ____
Street *City* *State* *Zip*

Phone ________________________________ Number of years at this address ______________

Previous Address ____
Street *City* *State* *Zip*

Phone ________________________________ Number of years at this address ______________

Are you legally permitted to work in the United States? Yes ___________ No ____________

EDUCATIONAL HISTORY

	Name & Location of School	No. of Yrs. Attended	Did you graduate?	Major Course of Study
High School or G.E.D.				
College				
Graduate School				
Trade, Business, or Correspondence School				

Please describe additional skills, training, or ability you would like to have us consider in evaluating your application: ____

____

EMPLOYMENT HISTORY

Are you employed now? ________________ If so, may we inquire of your present employer? ___________

Have you applied to be a Home Provider for Community Treatment Solutions before? _________________
When? ________

FORMER EMPLOYERS (List below last ten years of employment, starting with current employer)
Add additional page if necessary

Company/Firm: ____________________________ Address: _______________________________ ______________________________________ Telephone: _____________________________ Supervisor: _____________________________	(Mo./Yr.) From: To: Rate of Pay Start Finish	Job Title: _________________________ Duties: ___________________________ ________________________________ Reason For Leaving: ________________ ________________________________
Company/Firm: ____________________________ Address: _______________________________ ______________________________________ Telephone: _____________________________ Supervisor: _____________________________	(Mo./Yr.) From: To: Rate of Pay Start Finish	Job Title: _________________________ Duties: ___________________________ ________________________________ Reason For Leaving: ________________ ________________________________
Company/Firm: ____________________________ Address: _______________________________ ______________________________________ Telephone: _____________________________ Supervisor: _____________________________	(Mo./Yr.) From: To: Rate of Pay Start Finish	Job Title: _________________________ Duties: ___________________________ ________________________________ Reason For Leaving: ________________ ________________________________

Company/Firm: ______ Address: ______ ______ Telephone: ______ Supervisor: ______	(Mo./Yr.) From: To: Rate of Pay Start Finish	Job Title: ______ Duties: ______ ______ Reason For Leaving: ______ ______

REFERENCES (Give the names of three persons not related to you whom you have known at least one year) (One professional, two personal)

	Name	Address	Telephone	Occupation	Years Acquainted
(1)					
(2)					
(3)					

Are you able, with or without accommodation, to perform all of the essential functions of a Treatment Home Provider?

Yes ___________ No ____________

U.S. MILITARY SERVICE

Dates of Service: From __________ To ____________ Branch ________________________

Rank and Principal Duties: ____

____

Type of Discharge: ____

OTHER

Have you <u>ever</u> been convicted of a felony, misdemeanor or disorderly persons offence? Yes _____ No _____
Conviction will not necessarily disqualify an applicant from employment.

If "yes" please explain ____

____

Do you have a valid Driver's License? Yes ___________ No ____________ State __________

Have you been cited for any moving violations in the last three years? Yes ___________ No ____________

If "yes" please explain including date, charge and disposition: ________________________________

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Have you been involved in any automobile accident within the last three years? Yes ___________ No __________

If "yes" please explain including date, charge and disposition: ____

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____

FAMILY COMPOSITION (This information is required to meet State licensing guidelines):

NAME	AGE	RELATIONSHIP

Does anyone who is not a family member live in your household? Yes ___________ No ____________
If Yes, Please provide Name, Age & Relationship ____

Are you currently involved in any type of Paid or volunteer childcare in your home (i.e., DYFS, DDD, Day Care)?
Yes ___________ No ____________ If yes, Please explain: ____

____

All the above information contained above is accurate and truthful to the best of my knowledge. I have reviewed the contract and guidelines for governing Treatment Home Providers and the CTS Policy and Procedure Manual, and I understand that my contract with CTS may require flexibility; I will honor my commitment to the contract between me and CTS.

_______________________________________ _______________________________________
SIGNATURE DATE

LIABILITY RELEASE FORM

I, hereby give Community Treatment Solutions the right to make a thorough investigation into my references, employment, and education; and I release from all liability all persons, companies, and corporations supplying such information. I release, indemnify, and hold harmless Community Treatment Solutions from and against any and all liability, which might result from making such an investigation.

I understand that any false answer, statement, or representation made by me in this application shall be grounds for immediate cancellation of the Treatment Home Provider Agreement between Community Treatment Solutions and me. I also understand that nothing contained in this application, the granting of an interview, or the signing of a Treatment Home Provider Agreement is intended to create an employment contract between Community Treatment Solutions and myself for either employment or for the granting of benefits. No promises regarding employment or retention of services have been made to me and I understand that I am an independent contractor with whom Community Treatment Solutions has contracted for services. If an independent contractual relationship is established, I understand and agree that it is not for an indefinite period of time and that I have the right to terminate the contractual agreement after one year upon 30 days written notice to Community Treatment Solutions and that Community Treatment Solutions may terminate the contractual relationship immediately with cause or after one year upon 30 days written notice without cause.

I understand that, if accepted as an independent contractor for Home Services, it is necessary to abide by the rules and policies of Community Treatment Solutions as established by New Jersey law.

Date:____

Signature:____________________________________

CTS Witness:_________________________________

Community Treatment Solutions
Criminal Records Check Consent Form

Print Name:____________________________________ Date:__________________________

Address:______________________________________

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Social Security Number:___________________________

In order to serve the best interest of the children at Community Treatment Solutions, it is necessary to conduct criminal record checks on all volunteers and contracted consultants. Therefore, the following request for information must be completed and returned to the Human Resource Department prior to the signing of a Treatment Home Provider Agreement. Your signature on this form authorizes Community Treatment Solutions to obtain information from any law enforcement agency, court and/or record source and to investigate any matter deemed relevant to the evaluation of your suitability as a Treatment Home Provider for Community Treatment Solutions. All Treatment Home Provider applicants must complete this form.

Any falsification, misrepresentation or omission of requested information will result in denial of the application or immediate termination of the Treatment Home Provider application, regardless of when and how discovered.

Information obtained by a criminal record check will be used only for Treatment Home Provider purposes and only to the extent permitted by applicable law.

I have read and understand this request for information and agree to hold Community Treatment Solutions and employees harmless from any liability resulting from the use of the information requested. I will provide true, correct, and complete facts. I understand that misrepresentation or omission of facts will be grounds for denial of a contract as a Treatment Home Provider or immediate cancellation of a Treatment Home Provider Agreement.

____ ______________________________
Signature Date

CTS Witness:___________________________________ ______________________________
Date

DO NOT WRITE BELOW THIS LINE

Interviewer: Date:	Interviewer: Date:
Remarks:	Remarks:
______________________ Supervisor Signature	______________________ Date
Treatment Home Provider Contract: ___Approved ___Denied	Contract Date: __________ Contract Rate: __________

Notes:

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