CARE PROVIDER APPLICATION

CWI considers applicants for all positions without regard to race, color, religion, creed, gender, national origin, age disability, marital or veteran status or any other legally protected status.

Type of Position Applying For: In-Home Innovation CNA PCP

Specialized Training:________________________Languages Spoken:_________________________

Highest Education Level: GED High School Diploma BS/BS MS OTHER

DATE: ______________________________

1. Name: ____
Last, First, Middle/Maiden

Date of Birth: ________________________ Place of Birth______________________

Social Security Number: ___________________________(Copy also required)

2. Address: ____
(Street)

____
(City/State/ Zip)

Phone (____) _________________ Other Number (____) _______________________

Directions/distance to home from CWI office:
This is needed in considering proximity to consumers

____
____
____
____

3. Other Members of Household:

Name	Date of Birth	Relationship to Applicant	Place of Employment

4. Will you be able to provide a client with his/her private bedroom? **YES** or **NO**
(This is a requirement for overnight placements)

5. List any health//medical limitations (CWI does not discriminate on the basis of disabilities however; we will need to know if you have any limitations such as lifting, etc.)

** North Carolina requires an annual statement of good health from a doctor.
____
____
____
6. Do you have a valid North Carolina Driver's License? ____________________________
We will also need a copy. (Number)________________________

7. How did you learning about Care Well of Charlotte, Inc.?
____
____
____

8. Why do you want to become a care provider?
____
____
____

9. What do you have to offer an individual with developmental disabilities?
____
____
____ _____

10. Are you employed outside the home? ______ If so where? _______________

Working days and hours: ____

Working Phone Number: (___) ____________________
Can you be contacted at work by CWI if necessary? ______

11. References

BUSINESS
Business Name: ____
Contact Person: ____
Address: ____
Telephone Number: (____) _____________________________________

PERSONAL
Name: ____
Address: ____
Telephone Number (___) __________________________

12. Are you willing to have a physical and TB test? ____________
(Required by North Carolina for employment as care provider)

13. Have you ever been convicted of a felony or crime other than a misdemeanor? ___
(Police background check required prior to placement of a consumer)

14. Are you willing to participate in training sessions? _______

Business Name	Address	Phone Number and Contact Person	Date of Employment	Position	Salary

FOR RESIDENTIAL PLACEMENT ONLY

Is your home currently licensed? ________ License Expires: ______________

Fire//Safety Inspection? Date ________________

Smoke Detectors installed? ____________________

Fire extinguisher? ___________________________

Sanitation Inspection? Date _______________

This information that I have provided is accurate and correct to the best of my knowledge. The undersigned hereby acknowledge that he / she is not an employee of Care Well of Charlotte, Inc. and that my status with the company is that of an independent agent. In acting as a caregiver I acknowledge that all state and federal income taxes including federal social security taxes are my sole responsibility and not that of Care Well of Charlotte, Inc.

____ __________________________________

Signature Date

Care Well of Charlotte, Inc.
6608 East W.T. Harris Blvd Suite C & D
Charlotte North Carolina 28215-5125
Phone: 704-537-0052 Fax: 704-537-0056

Training and Orientation Requirements

These training sessions are provided in our office by individuals privileged to train direct care staff. These trainings are offered in a comfortable, non – threatening environment.

- ☐ CPR
- ☐ First Aid
- ☐ Medication Administration (not injection)
- ☐ Blood Borne Pathogen
- ☐ Incident / Accident reporting
- ☐ Client Rights
- ☐ Confidentiality
- ☐ Role /Purpose/ Philosophy of CWI services (Mission Statement)
- ☐ Seizure Management
- ☐ Documentation, Goal Planning and Individual Plan Process
- ☐ Stress Management
- ☐ Communication Techniques Consumer

Care Well of Charlotte, Inc.
6608 East W.T. Harris Blvd Suite C & D
Charlotte North Carolina 28215
Phone 704-537-0052 Fax 704-537-0056

Documents Required Prior to Placement of a Consumer

- ☐ Driver's License
- ☐ Social Security Card
- ☐ Copy of High School Diploma or Equivalent
- ☐ Driving Record Check (if client is going to be in care provider's home)
- ☐ Criminal Background Check (CWI obtains with your signed release)
- ☐ Medical / Physical Statement
- ☐ TB Test or Chest X – Ray
- ☐ Certificate of Insurance /Auto (if consumer will be in your car)
- ☐ Certificate of Insurance / Homeowners (If consumer will be in your home)
- ☐ Auto Registration

Assurance of Confidentiality

Care Well of Charlotte, Inc. is required to make known to all employees, students, volunteers and all other individuals with access to confidential information the provisions of the Federal Standards for Privacy of Individually Identifiable Heath Information and the North Carolina Statutes on Confidentiality (122C 51-56).

Care Well of Charlotte, Inc. is required by law to maintain the privacy of protected health information.

Protected health information as defined by the Federal Standards is: all individually identifiable health information that is transmitted or maintained in any form, including paper, oral and electronic records and communications.

Confidential information as defined in the N.C. Statutes " includes but is not limited to photographs, video tapes, audio tapes, client records, reimbursement records, verbal information relative to individuals served, client information stored in automated files and clinical staff member files ".

All information related to the individuals we support is confidential.

In accordance with the General Provisions (.0118) of the North Carolina Confidentiality Rules: Individuals with access to or control over confidential information shall take affirmative measures to safeguard such information.

Any release of confidential information:

• is authorizes in writing by the individual and / or the legally responsible person.

• is limited to the specific information identified and is the minimum necessary to fulfill the request

• has a time limitation not to exceed one year

• must allow for consent to be withdrawn at any time by the consenting individual

Once the authorization for release has been signed, only designated employees may approve the release of confidential information.

Examples: Information about an individual does not need to be discussed with individuals outside their team.

Employees will only have access to the individuals' information necessary to provide supports and services.

When an employee leaves and goes to another agency, any knowledge of individuals supported remains confidential and is not to be used by the new agency for or against the individual.

All employees shall indicate an understanding of the requirements governing privacy and confidentiality by signing a statement of understanding and compliance. These are signed upon employment and annually thereafter as required by funding source.

Confidentiality Statement

I understand and agree that all information related to individuals we support contained in records and observed at any location, must be kept confidential from unauthorized persons.

In accordance with Federal Standards for Privacy and N.C. Statutes on Confidentiality, I agree to hold confidential all information about applicants for placement, current and former individuals supported by Care Well of Charlotte, Inc. and other agencies to which I have access, Further, I agree not to divulge such information to any unauthorized persons. I understand that my failure to comply with the Federal Standards and the N.C. Statutes is a violation of client rights and may result in civil and / or criminal penalties punishable by fine or imprisonment and/or result in disciplinary action up to and including dismissal.

___________________________________ __________________
Signature/Title

Date ____________________________________

Care Well of Charlotte, Inc.

Receipt of Client Rights Policy and Procedures

I have received the required training of Care Well of Charlotte, Inc. Client Rights Policy and Procedures. I clearly understand the various types of violations that are covered by the Policy and Procedures and acknowledge that abuse can be physical, emotional or verbal and can include neglect or exploitation.

I understand that it is my responsibility as an employee to protect all individual we support from any harm; physical, emotional or verbal abuse, neglect, indignity, sexual offense and any other personal infringement. I also understand that corporal punishment is strictly prohibited.

I agree to immediately report any violations of any individual's rights that I personally witness or become aware of to my supervisor or Program Director. If, for any reason, I do not feel comfortable reporting violations to the above-mentioned individuals, I understand that I can report incidents directly to the Department of Social Services. I understand that my failure to report any violation of the Client Rights Policy will result in my immediate termination.

Receipt of Information Regarding the NC Health Care Personnel Registry Law

I understand that in accordance with the Registry Law Care Well of Charlotte, Inc. is required to report individuals with allegations of abuse, neglect, misappropriation of individual or facility property, fraud against the individual or facility and diversion of individual or facility drugs occurring in facilities. The registry contains a listing of unlicensed personnel who have been found to have caused harm to an individual or facility. Information from the Registry is available to the general public and all health care providers.

The information and reporting requirements regarding the law have been reviewed and explained to me. I have received the following: overview of Health Care Personnel Registry, Examples of Allegations, and Suggestions for Employees.

__________________________________ ____________________________________

Signature Date

__________________________________ _________________________________

Witness Date

CARE WELL OF CHARLOTTE, INC.

TB RISK QUESTIONNAIRE

Care Provider Name: ___________________________ Date _______________________

TB Risk Assessment	Yes	No	Don't Know
Do You Have:			
1. Close Contact with anyone who has tuberculosis?			
2. Any of these medical conditions:			
a. History of TB			
b. HIV Infection			
c. Diabetes mellitus			
d. High doses of Steroids/Immunesuppressive Therapy			
e. Chronic renal failure			
f. Leukemia/lymphoma			
g. Severly7 underweight			
3. Close contact with anyone who has arrived within 5 years from Africa, Asia, Latin America or Middle East?			
4. Close contact with anyone who is:			
a. HIV positive			
b. Homeless			
c. An IV drug user			
d. A migrant worker			
e. Employed by or resides at a correctional facility, homeless shelter, long term facility			
Comments:			

Care Provider Signature: ____________________________ Date: _______________

CARE PROVIDER APPLICATION
CARE WELL OF CHARLOTTE, INC.
CRIMINAL RECORD DISCLOSURE

I, ___________________________________ duly affirm that I do not have a Criminal record in North Carolina or any other state where I have resided. I understand that should I be found to have convictions or otherwise a record, I must disclose this information to Care Well of Charlotte, Inc. immediately. I understand that the administrative staff at Care Well of Charlotte, Inc. will review the nature of the crime and I may be terminated or suspended from my duties as determined by the review.

____
Signature **Date**

____
Signature of Witness **Date**