Care Well of Charlotte, Inc.

Care Provider Application

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

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 (_____) _____

   Direction to home from CWI office:
   _____
   _____
   _____
   _____
   _____
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?_____
   (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 Carolina Driver's License?_____
   We will also need a copy. (Number)

7. How did you learn 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: (_____)_____

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?_____

Please list your previous job experience- human service experience required.

Business Name	Address	Phone Number and Contact Person	Date of Employment	Position	Salary	Experience Verification Office Use

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.

_____ _____

Signed 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/immunosuppressive Therapy			
e. Chronic renal failure			
f. Leukemia/lymphoma			
g. Severely underweight			
3. Close contact with anyone who has arrived within 5 year 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:			