APPLICATION FOR EMPLOYMENT

Montana Community Services, Inc. is an equal opportunity employer and encourages diversity in employment. MTCS makes all hiring decisions without regard to an applicant's race, religion, sex, age, national origin, sexual orientation, disability or other protected classification under federal, state or local equal opportunity laws.

Name: _____ Date:_____
Last First MI

Address: _____City/State: _____ Zip Code: _____

Social Security Number: _____ Are you at least 18 years of age? YES___ NO___

Home Phone Number: _____ Work Phone Number: _____

Driver's License: State _____ License Number_____

Are you authorized to work in the United States on an unrestricted basis? YES___ NO___

Have you worked for a MTCS/REM company before? YES___ NO___

If yes, specify the position, company and dates: _____

EMPLOYMENT DESIRED

Position: _____ Wages Desired: _____ Date available:_____

Hours preferred: Part time_____ Full time_____ Relief_____ Temporary_____

Days/Times available: Mon _____ Tue _____ Wed _____

Thu _____ Fri _____ Sat _____ Sun _____

Are you willing to work overtime if necessary? Yes_____ No_____

How did you learn of this opening?_____

What cities/locations are you willing to work in?_____

Do you prefer to work with clients who are: Children_____ Adults_____ Seniors_____ No Preference_____

Some employment sites are home based. Are you willing to work in a home with pets? Yes___ No___

OIG check completed on (by MTCS Admin) _____ By _____
(date) (Signature/title)

Montana Community Services, Inc., 993 So. 24th St. W, Suite B, Billings, MT 59102
(406) 656-5976 Telephone, (406) 656-0128 Fax

QUALIFICATIONS

The use of illegal drugs is absolutely prohibited under MTCS policy.

YES_____ NO_____ Do you possess a valid driver's license?

Explain all YES answers below:

YES____ NO ___ Have you received three or more traffic violations in the last 3 years?
YES_____ NO ___ Has your driver's license been suspended or revoked in the last 3 years?
YES ____ NO___ Have you ever been convicted of or pled guilty to a felony?
YES ____ NO ___ Have you ever been convicted of or pled guilty to a crime involving the abuse, neglect or exploitation of a child or adult?

EDUCATION

COMPLETED YES	COMPLETED NO	NAME OF SCHOOL	ADDRESS	MAJOR	DEGREE
_____	_____	High School/GED			
_____	_____	Technical/Vocational			
_____	_____	College/University			
_____	_____	Other			

SPECIALIZED TRAINING, CERTIFICATION OR EXPERIENCE

YES	NO	TRAINING/CERTIFICATION	EXPIRATION DATE	ADDITIONAL COMMENTS
_____	_____	First Aid		
_____	_____	CPR		
_____	_____	Medication Administration		
_____	_____	Behavior Support /Diffusion		
_____	_____	Crisis Intervention		
_____	_____	Habilitation Principles /Techniques		
_____	_____	Feeding/Swallowing Techniques		
_____	_____	Positioning/ Transferring/Lifting		
_____	_____	Communication Techniques		
_____	_____	Defensive Driving		
_____	_____	Supported Living, Homemaker, Personal Care		
_____	_____	Bloodborne Pathogens		
_____	_____	Other:		

Do you have experience in providing care or treatment for persons with any of the following:

YES	NO	CONDITION	ADDITIONAL COMMENTS
_____	_____	Asthma/Breathing Difficulty	_____
_____	_____	Nebulizer Treatments	_____
_____	_____	Seizure Disorders	_____
_____	_____	Catheter Care	_____
_____	_____	Gastrostomy	_____
_____	_____	Feeding Tubes	_____
_____	_____	Bowel Programs	_____
_____	_____	Paralysis: Para/Quadriplegia	_____
_____	_____	Mental Health Issues	_____
_____	_____	Cerebral Palsy	_____
_____	_____	Muscular Dystrophy	_____
_____	_____	Vision Impairments/ Blind	_____
_____	_____	Hearing Impairments/ Deaf	_____
_____	_____	Memory Impairments/ Alzheimer	_____
_____	_____	Other	_____

Many of our locations are interested in applicants that are bilingual. Are you able to speak a language other than English?

YES___ NO___ Language spoken: _____

List any license or certification you possess that is relevant to the position you are applying for:

WORK HISTORY

MTCS and its affiliates bill Medicare for some of the services rendered. We must inform Medicare of any of employee that has employed by a Medicare Fiscal Intermediary during the past twelve months. If a Medicare Fiscal Intermediary has employed you in the past twelve months, please indicate the employer and the dates of employment.

If you are currently employed, may we contact your employer? YES_____ NO_____

WORK HISTORY

BEGIN WITH CURRENT OR MOST RECENT EMPLOYER OR POSITION WITH EMPLOYER:

(1) Employer: Address:

Supervisor: _____ Phone Number: _____

Dates of Employment: Starting date: _____ Ending date: _____ Ending Wage: _____

Position: _____ Description of Job: _____

Reason for Leaving: _____

(2) Employer: Address:

Supervisor: _____ Phone Number: _____

Dates of Employment: Starting date: _____ Ending date: _____ Ending Wage: _____

Position: _____ Description of Job: _____

Reason for Leaving: _____

(3) Employer: Address:

Supervisor: _____ Phone Number: _____

Dates of Employment: Starting date: _____ Ending date: _____ Ending Wage: _____

Position: _____ Description of Job: _____

Reason for Leaving: _____

(4) Employer: Address:

Supervisor: _____ Phone Number: _____

Dates of Employment: Starting date: _____ Ending date: _____ Ending Wage: _____

Position: _____ Description of Job: _____

Reason for Leaving: _____

(5) Employer: Address:

Supervisor: _____ Phone Number: _____

Dates of Employment: Starting date: _____ Ending date: _____ Ending Wage: _____

Position: _____ Description of Job: _____

Reason for Leaving: _____

REFERENCES

MTCS requires that all applicants submit six (6) references, which may include: current or former employers, supervisors, teachers or others qualified to objectively evaluate your ability to work in the position for which you have applied. Please list the reference information identified below. MTCS will be contacting each reference listed.

(1) Name: Relationship to Applicant

Address: Fax Number:

Daytime phone number: Nighttime phone number:

(2) Name: Relationship to Applicant:

Address: Fax Number:

Daytime phone number: Nighttime phone number:

(3) Name: Relationship to Applicant:

Address: Fax Number:

Daytime phone number: Nighttime phone number:

(4) Name: Relationship to Applicant:

Address: Fax Number:

Daytime phone number: Nighttime phone number:

(5) Name: Relationship to Applicant:

Address: Fax Number:

Daytime phone number: Nighttime phone number:

(6) Name: Relationship to Applicant:

Address: Fax Number:

Daytime phone number: Nighttime phone number:

THANK YOU FOR YOUR INTEREST IN MTCS

We at MTCS are pleased you are interested in becoming a member of our Company. We are proud of our excellent reputation and the services we provide. We value diversity and want your work experience to be enjoyable. Therefore, to help ensure a safe work environment and excellent services we carefully screen the background of all applicants. This screening may include an oral interview, as well as an investigation of your work history, driving record, application information, and reference check.

MTCS requires that an investigation of your background for any criminal conduct be completed upon conditional hire and annually thereafter.

APPLICANT DECLARATION OF UNDERSTANDING

__I understand that MTCS may conduct an investigation of the information I have noted on this application and, as part of that investigation, may contact prior employers and references, among others. I authorize MTCS to conduct this investigation and I release from all liability and hold harmless any person giving or receiving information about me relative to this investigation.

__I understand that any falsification, misrepresentation or omission of information discovered as a result of this investigation may prevent my being hired or if hired, may subject me to the immediate termination of my employment with MTCS.

__I understand that this application process does not create an employment contract.

__I understand all employment at MTCS is "at-will." This means, if MTCS employs me, my employment is not for a specified or definite period of time and that I may resign or be discharged from my position at any time, for any reason, with or without cause or prior notice.

__I understand that the "at-will" policy listed above cannot be changed or amended without a formal written employment agreement signed by me and by a member of the Board of Directors of MTCS.

__I declare that I have never committed nor been charged or convicted of any act of abuse, neglect, exploitation or fraud in relationship to a dependent/vulnerable child or adult, within the past 10 years.

__I declare that I have never knowingly violated any applicable rules or laws in any previous employment in a residential, healthcare or similarly related employment.

__I declare that the Office of Inspector General from participating in the Medicaid or Medicare programs has never excluded me.

BY SIGNING THIS APPLICATION, I AGREE THAT I HAVE READ AND UNDERSTAND THE DECLARATIONS LISTED ABOVE AND I ASSERT THAT ALL INFORMATION GIVEN IN THIS APPLICATION IS TRUE.

Date:_____ Signature:_____

DPHHS-QAD/CCL-20A
(Revision 11-10)

OFFICE USE
CAPS# _____
PS# _____

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

- RELEASE OF INFORMATION -
For Registered and Licensed Child Care Providers
Criminal / Protective Service / Motor Vehicle
Background Checks

PERSONAL INFORMATION

Section A – Current Information

Phone # _____

Legal Name: _____
(First) (Middle) (Maiden) (Last)

Aliases/Other Names Used: _____

Residential Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Sex: ☐ Male ☐ Female Date of Birth: _____ Social Security #_____

Section B – Past Residences

Within the last five (5) years, have you...

1. ...lived in another state? ☐ Yes ☐ No
2. ...lived on or do you now live in an area designated as an Indian reservation? ☐ Yes ☐ No

If you answered yes to the any of the above questions:

- Please state where you have lived since turning 18 in the table below.
- You will need to obtain an out of state background check or a tribal background check at your cost.

City	County	Reservation	State	Dates of Residency (From – To)

Section C – Prior Caregiver Approvals

Have you been... ...registered / licensed to care for children before? ☐ Yes ☐ No
...approved, in any capacity, to provide care in a child care facility? ☐ Yes ☐ No

IF YES: Please give the Director / Facility Name and the Dates at the facility.

_____ _____
(Director / Facility Name) (Dates)

_____ _____
(Director / Facility Name) (Dates)

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FACILITY INFORMATION

Section D – Employment Status

The facility that I am working / living at is: Provider #: 22-2930107

Director Name / Facility Name: Montana Community Services

Facility Mailing Address : 993 So. 24th St W, Suite B, Billings, MT 59102

My ROLE with this facility is (please check all that apply):

Center Use Only:

- ☐ Director
- ☐ Primary Caregiver
- ☐ Aide
- ☐ Substitute Provider
- ☐ Volunteer
- ☐ Non-Provider Staff

Family and Group Only:

- ☐ Director
- ☐ Caregiver
- ☐ Non-Provider Staff
- ☐ Substitute Provider
- ☐ Spouse
- ☐ Adult Child
- ☐ Other Adult
- ☐ Volunteer

My* START DATE *at this facility is: _____

Section E – Authorization Statement and Signature

I, _____ (applicant name), am aware that MT Community Services (provider or its authorized representative), has requested confidential information from the Montana Department of Public Health and Human Services, in accordance with 41-3-205(3)(o), MCA as part of a review of my personal background in connection with my status as a current or prospective employee of or volunteer for that entity.

I am aware that CFSD, DMV, and DOJ records may contain information that could adversely affect my employment or volunteer status and/or approval as outlined in ARM 37.95.161 and ARM 37.95.176. These records will relate to criminal history records, motor vehicle records as well as any report(s) of child abuse or neglect in Montana that indicates a risk to children. Records that indicate a risk to children are those that show a substantiation of child abuse/neglect on the person; and/or a history that shows that a child in the care of the person was adjudicated by a court as a youth in need of care, and/or a history that shows that the person has had their caregiver rights to a child terminated. As a household member, I understand that I am also subject to the above requirements.

I am also aware that although the entities or individuals requesting and receiving confidential CFSD information are bound by law or agreement with DPHHS to protect or preserve its confidential nature, DPHHS has no ability or authority to ensure that confidentiality is maintained after this information is released by DPHHS.

In full acknowledgement of the above information and notice, I authorize CFSD to provide the requested confidential information to the provider or its authorized representative identified above, and **I hereby also release CFSD from any claims or causes of action which may subsequently arise from release of this confidential information.**

NOTE: Any deletions or oversights may result in the denial of your application.

Signed: _____ Date: _____

(To be signed in front of a notary)

TO BE COMPLETED BY A NOTARY PUBLIC:

Taken, sworn, and subscribed before me this _____ day of _____ A.D. _____

_____

Notary Public for the State of Montana

Residing at: _____

My commission expires: _____

Print Form

Montana Department of Justice
MVD
Motor Vehicle Division
Safety • Efficiency • Dependability

Release of Driving Records

(Montana Driver Privacy Protection Act)

Print Form

P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-3933 • Fax (406) 444-1631

1. Requested Information: Are you requesting:

- ○ A. Your Driving Record – Complete Sections 3, 4, 5, and 6.
- ◉ B. Another Person's Driving Record – Complete all sections.

Intended Use: To be completed if you checked "B" above.

- ☒ With written consent of the individual(s) who are the subject(s) of this search - A signed and dated Personal Information Express Consent form must be attached.
- ☒ For use by a federal, state or local government agency, including a law enforcement agency or any individual acting on behalf of the agency in carrying out its functions.
- ☒ For use in matters concerning driver safety or vehicle theft.
- ☐ For use in matters concerning motor vehicle emissions.
- ☐ For use by motor vehicle manufacturers for vehicle alterations, recalls or advisories.
- ☐ For use by motor vehicle manufacturers for performance monitoring of motor vehicles or dealers.
- ☐ For use in matters concerning removal of non-owners from motor vehicles manufacturers original owners records for a vehicle.
- ☒ For use by a business or its agents, employees or contractors in their normal course of business to verify that volunteered personal information is accurate.
- ☐ For use by a business or its agents, employees, or contractors in their normal course of business to verify the accuracy of personal information submitted by the individual to the business or it agents, employees, or contractors. If the submitted information is not correct or no longer correct, to obtain the correct information for the purposes of preventing fraud by pursuing legal remedies against or recovering on a debt or security interest against the individual.
- ☐ For use as part of a civil, criminal, administrative or arbitrative proceeding in any court or government agency or before any self-regulatory body, including the service of process, an investigation in anticipation of litigation, and the execution or enforcement of judgments and orders, pursuant to an order of any court.
- ☐ For use to conduct research activities and produce statistical reports and journalistic articles as long as the personal information is not published, disclosed to a third party, or used to contact individuals.
- ☐ For use by an insurer, insurance support agency or self-insured entity in connection with the investigation of claims, antifraud activities, ratemaking or underwriting.
- ☐ For use in providing notice to the owners of towed, abandoned, or impounded vehicles.
- ☐ For use by a licensed private investigator or security service for any purpose authorized under Montana law.
- ☐ For use by an employer or its agent to verify information related to a holder of a commercial driver's license required under federal or Montana law.
- ☐ For any other use that is specifically related to the operation of a motor vehicle or to public safety and is authorized under Montana law.
- ☐ For use by a parent of a child under 18 year of age.

2. Requestor Information:

Name of Requestor: Sandie Sullins

Employer/Company: (if applicable) Montana Community Services, Inc.

Mailing Address: 993 S. 24th St. West Suite B City: Billings State: MT Zip: 59102

Residential Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone #: 406-656-5976 Driver's License #: _____

3. Search Information: This section must be complete.

Full Name: _____

Date of Birth: _____

Driver's License #: _____

4. Driving Records Fees:

Make checks payable to Motor Vehicle Division

- ☒ Driving Record = $4.00 per record
- ☐ Certified Driving Record = $10.00 per record * Cannot Be Faxed *
- ☐ Faxing of Record = Additional $3.00 per record
  Fax #: _____
- ☐ Mailing of Record = Additional $ 3.00 per mailing (unless self-addressed, stamped envelope is included.)

Total = $ _____

Section 6 notarization must be completed – OR – you must attach a legible copy of your state or government-issued photo ID, including driver's license, identification card or passport, none of which can be expired for more than four years.

5. Certification: (Signature must be notarized unless a copy of requestor's Driver's License or State Issued Identification Card is enclosed.)

I have read the "Montana Driver Privacy Protection Act" MCA 61-11-501 through 61-11-516, and understand the limitations placed on the use of information received from the Montana Department of Justice, Motor Vehicle Division, Records and Driver Control Bureau. I certify under penalty of law (MCA 45-7-203 Unsworn Falsification to Authorities) that the statements made and information contained on this request are true and correct to the best of my knowledge, information and belief, and if I am signing for a commercial entity, I further certify that I have full authority to do so.

Signature of requestor: _____

Printed Name: _____ Date: _____

6. Notarization: (unless ID is provided)

Subscribed and sworn before me this _____ day of _____, 20 ____.

Signature: _____

Print or Type Name: _____

Notary Public for the State of: _____

Residing at: _____

My commission expires: _____

(seal)

Montana Department of Justice
MVD
Motor Vehicle Division
Safety • Efficiency • Dependability

Personal Information Express Consent Form

P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-3933 • Fax (406) 444-1631

This form is to be used to authorize the Department of Justice, Motor Vehicle Division, to release certain records to another person or entity. Complete this form if you have checked the first box of the **Intended Use** portion of Section 1 on the Release of Driving Records form (34-0100).

Name: _____
Print Full Name

Driver's License #: _____ Date of Birth: _____

Residing at: _____
Street City State Zip Code

I hereby authorize the Department of Justice to release my:
☑ Driving Record ☐ Vehicle Record

To the following individual and/or company:

Name: Sandie Sullins / Montana Community Services, Inc.
Print Full Name

Address: 993 So. 24th St. W, Suite B Billings MT 59102
Street City State Zip Code

I certify under the penalty of law **(MCA 45-7-203 Unsworn Falsification to Authorities)** that the statements made herein are true and correct to the best of my knowledge, information and belief.

Signature: _____ _____
This is my legal signature Date

Printed name: _____