PROVIDER / APPLICANT INFORMATION SHEET

(Please print clearly)

NAME: ____ Type of Care ______________________
(Please see below)

HOME ADDRESS: ____

____

Is this your mailing address? ☐ Yes ☐ No START DATE_________________________

MAILING ADDRESS: ____
(if different than above)

____

EMAIL____

PHONE NUMBERS: HOME ______________________ CELL/PAGER______________________

WORK _________________________ FAX___________________________

DATE OF BIRTH: ____________________ SOCIAL SECURITY NO: ________________________

CLIENT ____ New______ Current_______

Do you have these Trainings? AWMD_______ (Date) CPR/FIRST AID_______ (Date) Incident Reporting________ (Date)

RECOMMENDED BY_____________________ COORDINATOR ____________________________

This Section – Internal Use Only

Documents on File:

- ☐ Personalized Timesheets
- ☐ AFS Contract
- ☐ Home Study/Health & Safety Study
- ☐ Signed Release
- ☐ Application/Identification
- ☐ Direct Deposit
- ☐ W-9
- ☐ Self-Assessment(s)
- ☐ Background Check Documents
- ☐ Clearance Letter
- ☐ Compliance/Training – Current
- ☐ Annual Review (if applicable)

Type of Care: (please circle if applicable)
Community Access
Family Living
Independent Living
Respite Care
Substitute Care
Adult Habilitation
Personal Support