PERSONAL INFORMATION:

First Name _____

Middle Name _____

Last Name _____

Social Security Number _____

Street Address

_____

City, State, Zip Code

_____

Phone Number

(___)_____

Are you eligible to work in the United States?

Yes_____No_____

If you are under age 18, do you have an employment/age certificate?

Yes____No ____

Have you been convicted of or pleaded no contest to a felony within the last five years?

Yes_____No_____

If yes, please explain: _____

POSITION:

Position Applied For

_____

What date are you available to start work?

_____

EDUCATION:

Name and Address of School - Degree/Diploma - Graduation Date

_____

_____

_____

Skills and Qualifications: Licenses, Skills, Training and Awards

_____

_____

EMPLOYMENT HISTORY:

Present Or Last Position:
Employer: _____

Address:_____

Supervisor: _____

Phone: (____) ____-_____Email: _____

Position Title: _____

From:_____To: _____

Responsibilities: _____

_____

Salary:_____

Reason for Leaving: _____

References:

Name/Title Address Phone

_____

_____

_____

I certify that information contained in this application is true and complete.

Signature_____

Date_____

CONFIDENTIAL

Our participants have the right to privacy when it concerns to their personal/medical care.
Our participants have a right to decide what personal health information can be shared, how and with whom. This information is confidential and should only be given to those who need to know to provide appropriate support/care.

Best Practices:

- Keep your participant's dignity in mind when discussing health information.
- Be mindful of your surrounding when discussing private matter/issues.
- Do not talk about participants in public areas.
- Be private and conduct discreetly any case discussion, consultation, examination or ISP plan.
- Avoid using waiting rooms or public areas to interview participants or to brief family members.
- Keep faxes confidential – use cover sheets, double check fax numbers, ensure someone is there to receive the information. Do not leave faxes lying around.
- Do not discuss sensitive participant information when using speakerphones, answering phone calls.

Employee Signature_____Date_____

Authorization For Release of Information

Background Check Disclosure

As part of the employment process, Lyons Support Services, LLC hereby known as ("the company"), may obtain a consumer report and / or Investigative Consumer Report. The Fair Credit Reporting Act as amended bythe Consumer Reporting Reform Act of 1996 requires that we advise you that for the purposes of employment only, a Consumer Report may be made which may include information about your character, general reputation, personal characteristics, or mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided in the event the Report contains information regarding your character, general reputation, personal characteristics, or mode of living.

Authorization and Release

During the application process and at any time during any subsequent employment, I hereby authorize _____(any search Company) to procure a Consumer Report which I understand may include information regarding my Driver Record, character, general reputation, personal characteristics, or mode of living. This report may include Criminal Records, Credit reports, Driving Records, Past Employment or Education Verifications, Worker's Compensation Claims, and any other source required to verify information that I have voluntarily supplied. I understand that I may request a complete and accurate disclosure of the nature and scope of the background verification to the extent such investigation includes information bearing on my character, general reputation, personal characteristics or mode of living. I authorize without reservation, any party or agency contacted to furnish the above mentioned information and release all parties involved from liability and responsibility for doing so. This authorization and consent shall be valid in original, fax, or copy form.

_____

Applicant / Employee Name Date

_____

Applicant / Employee Signature Birth Date

_____

Social Security Number

_____

Current Address

_____

Driver's License Number and State

AUTHORIZATION TO RELEASE INFORMATION

I _____hereby authorize Lyons Support Services or any other organization or person having any records, data,or information concerning me to furnish such records, data,or information to FLP Support Services for the purpose of employment.

I understand that Lyons Support Services will keep such information confidential. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. This form is to be used for employment purpose only.

Signature of applicant_____

Date_____

HIPAA Security Training Certificate

In Reference to Health Insurance Portability and Accountability Act (HIPAA).

I understand and agree that it is my responsibility to maintain confidentiality for all participants while working for Lyons Support Services and their clients. I understand that protecting the confidentiality and security of patient information includes protecting both the participant's personal identity and the participant's health related information.

I understand that any use, sale, barter, or disclosure of confidential patient information for purposes outside of the scope of my employment is prohibited, and that such disclosure may also be in violation of state and/or federal law. Violating confidentiality outside of the scope of my employment may lead to loss of employment and potential personal liability for civil or criminal penalties.

I further understand that disclosure of patient information necessary for purposes of treatment, payment, for services, or health care operations is permissible. When making such disclosure of patient information, I must limit disclosure to the minimum necessary information to accomplish the task required.

_____	_____	_____
Print Associate Name	Employee signature	

Individual In-Service Record

I_____(please print) have reviewed or will take mandatory courses for compliance with DDD Mandatory Topics on:

Unusual Incident Report, Confidentiality and Privacy under HIPAA, Fire/Personal Safety, Infection Control, CPR, First AID and other CDS online training courses

Employee Signature_____Date_____

Lyons Support Services

Dear Employee: _____

Lyons Support Services is honored that you have chosen to work for us as a Direct Support person (DSP)

Your compensation rate would be as follows :

$_____ Per hour

Your signature below is an acknowledgement of the Orientation and hourly rate.

Employee signature _____

Date _____