

# REQUEST FOR CONSIDERATION GREEN MOUNTAIN SUPPORT SERVICES, INC.

93 James Road  
Morrisville, VT 05661

Dear Applicant,

Attached you will find a 16 page comprehensive application (request for consideration) to become a developmental home provider. There are 4 distinctive parts (explained below) which all must be completed in full before being reviewed. Once we receive your complete application it will be held on file for 1 year. We will review your application and evaluate for compatibility as positions become available. Should a potential match be identified, you will be contacted for an interview. There is no need to fill out a new application or contact us within the one year time frame. Should you like to remain on our list for consideration after one year, please complete a new application.

1. Applicant Information – Please answer all questions to the best of your ability/knowledge. Your direct and indirect work experience will help us to find a potential match. Your previous employers and professional references may be contacted to determine your professional character. Please note that Green Mountain Support Services is required to submit reference checks to a number of State Agencies as part of the consideration process.
2. Client Match Survey - This survey assists us in determining the best match between contractor and client. Please complete it honestly and note any questions, concerns or clarifications to your answer on the back.
3. Applicant Statement/Authorization for Release of Information/Disclosures – authorizes Green Mountain Support Services to check references and conduct required background checks, and clarifies policies regarding such issues as confidentiality and employment status. All applicants must sign the Applicant Statement.
4. Personal References - 3 Personal Reference forms are included in the application. These forms need to be completed and returned to Green Mountain Support Services. They are a fundamental piece of the application process. **It is your responsibility to ask each of your references to fill out the form.** References can be returned to you, or mailed directly to GMSS. If GMSS receives an incomplete reference form, we will return it to you with the expectation that you will distribute it for completion. Each reference can cover one or both applicants in a joint application. Our mailing information is provided on the form for your convenience.

Thank you for your interest in providing a home and support to the individuals we support. Please submit the application electronically via our website, or mail your completed application to:

Green Mountain Support Services  
93 James Road  
Morrisville, VT 05661  
Attn: Chelsea Miller

**REQUEST FOR CONSIDERATION  
GREEN MOUNTAIN SUPPORT SERVICES, INC.**

93 James Road  
Morrisville, VT 05661

**This application will remain on file for 12 months from date of receipt.**

*WITH THE EXCEPTION OF SIGNATURE, PLEASE PRINT ALL INFORMATION LEGIBLY.*

<b>SECTION 1: APPLICANT INFORMATION</b>			<b>Date:</b>	
<b>Name:</b>		<b>Date of Birth:</b>		
<i>Please check best way of communication:</i>				
<b>Home Phone:</b>		<b>Cell Phone:</b>		
<b>Email:</b>				
<b>Spouse/ Domestic Partner:</b>				
<b>Name:</b>		<b>Date of Birth:</b>		
<i>Please check best way of communication:</i>				
<b>Home Phone:</b>		<b>Cell Phone:</b>		
<b>Email:</b>				

**PLEASE COMPLETE THE FOLLOWING AS IT RELATES TO YOUR HOUSEHOLD:**

**Mailing Address**

Street Address	Town	State	Zip Code
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**Physical Address**

Street Address	Town	State	Zip Code
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Has your home been inspected by the State of Vermont?      YES       NO

If yes, what year and for what Agency?

**How did you learn about us? Please be specific.**

- Newspaper:
- Radio Ad
- TV Commercial
- Word of mouth, WHO:
- Previously worked for GMSS? If, so When?
- Other:

Do you have any personal experience working with individuals with disabilities? If yes, please explain.

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What is your motivation for becoming a Shared Living Provider?

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Do you currently provide care in your home to any other vulnerable individuals (aged or disabled family members, foster children or agency-placed) at this time?

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**Household Composition:** List ALL household members, including all minors who reside in the home. (Place an \* next to the name of any Co-Applicants who will assist in providing care.)

<u>Name:</u>	<u>Age:</u>	<u>Relation to Provider:</u>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Are there other children/teens who do not live in the home but visit regularly? Please elaborate, ages, gender, relationship and frequency of visits.

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About the Home

Type of Home      House                      Apartment                      Mobil Home                      Other

Do you rent or lease your home?

Do you have homeowners or renters insurance?

If you are renting or leasing, is your landlord aware of your interest in becoming a shared living provider for individual with development disabilities?

Is your home handicap accessible?

Does your home have a ramp?

How many stair to enter the home?

How many bedrooms do you have available to support an individual with developmental disabilities?

What floor will the individual be occupying?

Will the individual have their own bathroom?

Do you have an in-law apartment available for the individual? If yes, please describe.

How do you heat your house?

Do you or anyone living in with you smoke?

Are you willing to let the individual smoke at your home?

Are there alcoholic beverages kept in your house?

If yes, how are alcoholic beverages stored?

Are prescription or over the counter medications kept in your house?

If Yes, How are medications stored?

Are any guns kept in the house?

If yes how are guns and ammunition stored?

PETS (If yes, list how many and what animals are living on the property.)

Do you have pets in the home?

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Do you have pets outside of the home?

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Would you be willing to let the individual bring a pet with them?

## Client Match Information

Please (X) the answer that best reflects your response to each statement. There is no right (or wrong) answer to any of these statements and an inability or unwillingness to provide some types of support does not reflect poorly upon you as an applicant. This questionnaire merely helps us to get to know you so that we can make the best possible match for the individuals we support.

**Please the boxes you'd be willing to support in your home and around with you**

### Behaviors

<input type="checkbox"/>	Physical aggression towards you or others	<input type="checkbox"/>	Verbal aggression towards you or others.
<input type="checkbox"/>	Outward expression of frustration	<input type="checkbox"/>	Running away
<input type="checkbox"/>	Stealing things from others	<input type="checkbox"/>	Sloppiness
<input type="checkbox"/>	Extreme moodiness	<input type="checkbox"/>	Poor Hygiene
<input type="checkbox"/>	Depression, withdrawn from others	<input type="checkbox"/>	Overeating or constant eating
<input type="checkbox"/>	Lack of attentiveness	<input type="checkbox"/>	Hyperactivity
<input type="checkbox"/>	Self harm- pinching, biting or head bang	<input type="checkbox"/>	Bedwetting
<input type="checkbox"/>	Difficulty trusting others	<input type="checkbox"/>	Constant need of attention
<input type="checkbox"/>	Refusal to take medication	<input type="checkbox"/>	Sexual acting out behaviors
<input type="checkbox"/>	medical problems	<input type="checkbox"/>	School problems
<input type="checkbox"/>	Trouble with the law	<input type="checkbox"/>	Abuses/Abused Alcohol
<input type="checkbox"/>	Used/Abused Drugs	<input type="checkbox"/>	Uses Medical Marijuana
<input type="checkbox"/>	History of neglect by their parents	<input type="checkbox"/>	History of physical abuse
<input type="checkbox"/>	History of sexual abuse	<input type="checkbox"/>	History of emotional abuse

### Health

<input type="checkbox"/>	Uses a wheelchair	<input type="checkbox"/>	Inconstant of bowel/ bladder
<input type="checkbox"/>	Special care procedures	<input type="checkbox"/>	Uses colostomy bag
<input type="checkbox"/>	Learn special care procedures	<input type="checkbox"/>	Inability to communicate with words
<input type="checkbox"/>	Blindness	<input type="checkbox"/>	Needs help with toileting and hygiene
<input type="checkbox"/>	Seizures	<input type="checkbox"/>	HIV/AIIDS or Hepatitis
<input type="checkbox"/>	Requires periodic attention during sleep	<input type="checkbox"/>	End of life care

### Sexuality

<input type="checkbox"/>	Supportive of romantic/sexual relationship	<input type="checkbox"/>	Gay/lesbian romantic/sexual relations
<input type="checkbox"/>	Allow sex in my home	<input type="checkbox"/>	Allow sexual aids in my home



**PLEASE COMPLETE THE FOLLOWING PERSONAL/EMPLOYMENT INFORMATION:**

**Primary Care Provider**

Have you ever been a Home Provider for people with disabilities?		<b>YES</b>	<b>NO</b>
If yes, for what Agency?			
Transportation			
Do you have a valid driver's License		YES	NO
Do you have a reliable and insured vehicle?		YES	NO
Make:	Model:	Year:	
Do you have a vehicle that is handicap accessible:		YES	NO
Have you had any traffic violations in the past 3 years		YES	NO
Have you ever been convicted of a crime or had a substituted charge of abuse, neglect, exploitation, misuse of funds or other crimes inimical to the public welfare within Vermont or outside of the State of Vermont?		YES	NO
If Yes, Please explain:			

Have you resided in any state other than Vermont?		YES	NO
If Yes, Where and for how long:			

List all certifications, training or experience relevant to providing this type of service.		
Subject:	Date:	
Subject:	Date:	
Subject:	Date:	
Subject:	Date:	

Please list 3 Personal References:

Name:	Phone Number:
How long have you know this person:	Email:

Name:	Phone Number:
How long have you know this person:	Email:

Name:	Phone Number:
How long have you know this person:	Email:

I am currently:	Employed out of the home	Working from home	Unemployed but looking
Other:			
I work	Hours per week	My work hours are	To

<b>Current Employer Information</b>	May we contact this Employer :	YES	NO
Company Name	Job Title		
Address:	Phone Number		
Supervisor Name:	Start Date	End Date	
Reason for Leaving:			

<b>Previous Employer Information</b>	May we contact this Employer :	YES	NO
Company Name	Job Title		
Address:	Phone Number		
Supervisor Name:	Start Date	End Date	
Reason for Leaving:			

<b>Previous Employer Information</b>	May we contact this Employer :	YES	NO
Company Name	Job Title		
Address:	Phone Number		
Supervisor Name:	Start Date	End Date	
Reason for Leaving:			

Please list 3 Profession References:

Name:	Phone Number:	Profession
How long have you know this person:	Email:	

Name:	Phone Number:	Profession
How long have you know this person:	Email:	

Name:	Phone Number:	Profession
How long have you know this person:	Email:	



**SECTION 3**

**APPLICANT STATEMENT**

I/We authorize any review of my/our experience/education and verification of all data given, related papers or oral interview. I/We release from liability any person giving or receiving such information.

Any material misrepresentation or deliberate omission of a fact on this Request for Consideration may be justification for refusal of or if contracted with, termination of said contract with Green Mountain Support Services, Inc.

I/We understand that as part of the consideration process, Green Mountain Support Services is required to submit my name to the VT Agency of Human Services Departments of Children and Families and Adult Protective Services as well as Vermont Criminal Information Center, Vermont Department of Motor Vehicles and Office of the Inspector General in order to conduct criminal background checks. I/We hereby authorize Green Mountain Support Services, Inc. to do so.

Any offer of a contract by Green Mountain Support Services, Inc. is contingent upon the content of information received by the state and government agencies listed above.

I/We have received a copy of the following disclosures related to my/our application:

- Privacy
- Confidentiality
- Employment Status

I/We hereby authorize Green Mountain Support Services, Inc. to contact references listed, except as otherwise noted.

I/We have read and understand the above.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date

## **APPLICANT'S COPY**

Read completely and keep in a safe place.

### **PRIVACY DISCLOSURE**

The content of this application is confidential. Its use shall be limited to screening the applicant/co-applicant(s)' eligibility to provide specialized home services to prospective participants. Within that purpose, responses contained may be reviewed by the program and administrative staff of Green Mountain Support Services, Inc. No other use of information contained in this application shall be made without the written permission of the applicant/co-applicant(s).

### **CONFIDENTIALITY DISCLOSURE**

Staff and contracted Service Providers will keep confidential all information about CLIENTS and other MEMBERS OF THE GREEN MOUNTAIN SUPPORT SERVICES COMMUNITY.

Program staff, contracted service providers and volunteers will follow the Green Mountain Support Services, Inc. Confidentiality Policy that reads as follows:

Client information is confidential. It shall not be discussed with unauthorized personnel. Only those employees directly involved with providing care and support of client or those clerical personnel authorized to handle client materials shall have access to records and other relevant data. Client information is to be used in clinical discussions relative to treatment planning with appropriate respect for the identity of the client and sensitivity regarding the content. Violations of the confidential nature of client information will be grounds for immediate dismissal.

### **EMPLOYMENT STATUS DISCLOSURE**

Eligibility as a Developmental Home Provider, if established pursuant to this application, does not constitute employee status with Green Mountain Support Services, Inc. rather, the eligible provider shall be considered an independent contractor. Compensation to the provider shall be determined by funds and/or the third part funding source, and shall be based upon individual participant(s)' eligibility and need for services.

**SECTION 4 – Personal Reference 1:**

PERSONAL REFERENCES

Green Mountain Support Services, Inc. is a private non-profit Specialized Service Agency that provides residential services to disabled adults and children.

Individuals with disabilities who need extra support in various areas of daily living skills share a home with a family or individual within the community. The intent of this program is that the person receiving services becomes an integral part of the family, with the security, consistency, and responsibility with which that entails.

Within this program respite services are often provided for the family. The respite provider must be a responsible person who is able to provide a safe and secure atmosphere for our consumers with many of the same qualifications as expected of the Shared Living Provider.

The person named below has applied to Green Mountain Support Services, Inc. to become a contractual Shared Living Provider and has given us permission to check references. We would sincerely appreciate you providing the information requested and any additional comments which will assist us in evaluating his/her character and ability to provide such care. Any information furnished should be returned with the Request for Consideration by the potential contractor or mailed directly to Green Mountain Support Services, Inc., Attn: Chelsea Miller, 93 James Road, Morrisville, VT 05661 and will be regarded as confidential. Thank you.

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Name of Potential Contractor

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Maiden or Alias Name

I authorize \_\_\_\_\_, whose address is \_\_\_\_\_

\_\_\_\_\_, to provide an opinion as to my suitability for providing contractual

services for an individual with disabilities. I have read and understood the contents of this form. With this

authorization, I hereby release you and Green Mountain Support Services, Inc. from any and all liability for providing this information regardless of the truth or falsity thereof.

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Signature of Potential Contractor

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Date

**SECTION 4 – Personal Reference 1 (continued):**

1. Would you recommend this person as a potential contractor? YES\_\_\_NO\_\_\_
2. How long have you known this person/family? \_\_\_\_\_
3. Describe in what capacity and how well you know the potential contractor(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. What is your understanding of their motivation to provide this service? \_\_\_\_\_  
\_\_\_\_\_
5. Do their family members and relatives support the idea? \_\_\_YES \_\_\_NO
6. Please describe what you know about the potential contractor's individual personality and their relationships within their home, family and community. \_\_\_\_\_  
\_\_\_\_\_
7. Please provide your opinion of the potential contractor's ability to care for a vulnerable person with special needs and to act as an appropriate role model for someone who may need help with their social skills. Please comment on any special skills and interests they have which might enrich a person's life. \_\_\_\_\_  
\_\_\_\_\_
8. What kind of person do you feel the potential contractor(s) would best be able to share their lives and home with i.e. male/female, active/sedentary, verbal/non-verbal, child/adult, etc.? \_\_\_\_\_  
\_\_\_\_\_
9. Is there any type of person with special needs whom you feel **would not** do well with the potential contractor/family i.e. challenging behaviors, personal care/hygiene challenges, extreme medical challenges, etc.? \_\_\_\_\_  
\_\_\_\_\_
10. Do you have any reservations about this family/individual providing contractual services? \_\_\_\_\_
11. Any additional comments? \_\_\_\_\_  
\_\_\_\_\_

Please provide a telephone number and the best hours to reach you, in case we need to contact you for clarification or further information. \_\_\_\_\_

Please sign and date your reply.

\_\_\_\_\_  
Signature of Reference

\_\_\_\_\_  
Date

**Personal Reference 2:**

PERSONAL REFERENCES

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\_\_\_\_\_  
Name of Potential Contractor

\_\_\_\_\_  
Maiden or Alias Name

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\_\_\_\_\_  
Signature of Potential Contractor

\_\_\_\_\_  
Date

**Personal Reference 2 (continued):**

1. Would you recommend this person as a potential contractor? YES\_\_\_NO\_\_\_
2. How long have you known this person/family? \_\_\_\_\_
3. Describe in what capacity and how well you know the potential contractor(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. What is your understanding of their motivation to provide this service? \_\_\_\_\_  
\_\_\_\_\_
5. Do their family members and relatives support the idea? \_\_\_YES \_\_\_NO
6. Please describe what you know about the potential contractor's individual personality and their relationships within their home, family and community. \_\_\_\_\_  
\_\_\_\_\_
7. Please provide your opinion of the potential contractor's ability to care for a vulnerable person with special needs and to act as an appropriate role model for someone who may need help with their social skills. Please comment on any special skills and interests they have which might enrich a person's life. \_\_\_\_\_  
\_\_\_\_\_
8. What kind of person do you feel the potential contractor(s) would best be able to share their lives and home with i.e. male/female, active/sedentary, verbal/non-verbal, child/adult, etc.? \_\_\_\_\_  
\_\_\_\_\_
9. Is there any type of person with special needs whom you feel **would not** do well with the potential contractor/family i.e. challenging behaviors, personal care/hygiene challenges, extreme medical challenges, etc.? \_\_\_\_\_  
\_\_\_\_\_
10. Do you have any reservations about this family/individual providing contractual services? \_\_\_\_\_
11. Any additional comments? \_\_\_\_\_  
\_\_\_\_\_

Please provide a telephone number and the best hours to reach you, in case we need to contact you for clarification or further information. \_\_\_\_\_

Please sign and date your reply.

\_\_\_\_\_  
Signature of Reference

\_\_\_\_\_  
Date

**Personal Reference 3:**

PERSONAL REFERENCES

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\_\_\_\_\_  
Name of Potential Contractor

\_\_\_\_\_  
Maiden or Alias Name

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\_\_\_\_\_, to provide an opinion as to my suitability for providing contractual

services for an individual with disabilities. I have read and understood the contents of this form. With this

authorization, I hereby release you and Green Mountain Services, Inc. from any and all liability for providing this information regardless of the truth or falsity thereof.

\_\_\_\_\_  
Signature of Potential Contractor

\_\_\_\_\_  
Date

**Personal Reference 3 (continued):**

1. Would you recommend this person as a potential contractor? YES\_\_\_NO\_\_\_
2. How long have you known this person/family? \_\_\_\_\_
3. Describe in what capacity and how well you know the potential contractor(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. What is your understanding of their motivation to provide this service? \_\_\_\_\_  
\_\_\_\_\_
5. Do their family members and relatives support the idea? \_\_\_YES \_\_\_NO
6. Please describe what you know about the potential contractor's individual personality and their relationships within their home, family and community. \_\_\_\_\_  
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7. Please provide your opinion of the potential contractor's ability to care for a vulnerable person with special needs and to act as an appropriate role model for someone who may need help with their social skills. Please comment on any special skills and interests they have which might enrich a person's life. \_\_\_\_\_  
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\_\_\_\_\_
9. Is there any type of person with special needs whom you feel **would not** do well with the potential contractor/family i.e. challenging behaviors, personal care/hygiene challenges, extreme medical challenges, etc.? \_\_\_\_\_  
\_\_\_\_\_
10. Do you have any reservations about this family/individual providing contractual services? \_\_\_\_\_
11. Any additional comments? \_\_\_\_\_  
\_\_\_\_\_

Please provide a telephone number and the best hours to reach you, in case we need to contact you for clarification or further information. \_\_\_\_\_

Please sign and date your reply.

\_\_\_\_\_  
Signature of Reference

\_\_\_\_\_  
Date