



Building care and understanding in the communities we serve

EMPLOYMENT APPLICATION

Name:	Email:		
Address:	Phone #: Cell #:		
City/State/Zip:	Date of Application:		
Position Applying for*			
Are you available to work	Full Time	Part Time	
When would you be available to begin work?			
* <u>Direct Service Positions</u> – Are you 21 years of age or older?	Yes	No	
Are you able to travel if required?	Yes	No	
Can you provide transportation for self?	Yes	No	
Can you provide transportation for clients?	Yes	No	
Do you have a legal right to work in the U.S? <i>Proof of identity & eligibility will be required upon hire.</i>	Yes	No	
Have you ever been convicted of a crime? (Includes Felony, Misdemeanor or OUI) <i>A conviction will not necessarily result in denial of employment.</i>	Yes	No	If Yes – explain with dates & details
Have you ever been investigated for abuse, neglect or Exploitation of a youth or vulnerable adult?	Yes	No	If Yes – explain with dates & details
Have you ever, in this state or any other state, had a license or certification (e.g. professional license, driver's license) revoked or suspended, or have you ever voluntarily surrendered a license or certification?	Yes	No	If yes – explain with dates & details
Have you ever worked for Community Care before?	Yes	No	If yes - explain with dates & details
Are you related to anyone who works at Community Care or contracts with Community Care?	Yes	No	If yes – please indicate name & relationship.
Referral Source:	<input type="checkbox"/> Adv. <input type="checkbox"/> Friend <input type="checkbox"/> Current Employee – Name: _____ <input type="checkbox"/> Website-Jobsinme.com <input type="checkbox"/> Website-other _____ <input type="checkbox"/> Other _____		

EDUCATION

Name of School	Address	Grade Completed	Major/Degree
CPR Currently Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No Expires _____ First Aid Currently Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No Expires _____ Mandt Currently Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No Expires _____ MHRT-C Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No MHRT-1 Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No Clinical Therapists - Current Maine State Licensure (LCPC, LCPCcc, LMSWcc, or LMFT) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Professional license(s) or certification(s) currently held (include numbers if Applicable):			
Have you completed a bachelor's degree?	Yes	No	If no, when do you expect to complete?
Have you completed a master's degree?	Yes	No	(if no, when do you expect to complete?)

WE ARE AN EQUAL OPPORTUNITY EMPLOYER. WE DO NOT DISCRIMINATE ON THE BASIS OF RACE, RELIGION, COLOR, SEX, SEXUAL ORIENTATION, AGE, NATIONAL ORIGIN OR DISABILITY

Have you reviewed the essential duties of the position for the job for which you are applying? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you able to perform the duties of the position for which you have applied with or without accommodations? <input type="checkbox"/> Yes <input type="checkbox"/> No

WORK EXPERIENCE (PRESENT TO PAST)

Start with the most recent position and move backward through all positions and military service for the past twenty years, including employed months and year.

Furnish dates and explanations for each period of unemployment of one month or more. You may exclude employment during high school.

THIS FORM MUST BE COMPLETED IN FULL (Please do not leave spaces blank with a note to "see attached resume.")

Use the next page for additional space as necessary.

Employer:	Address:		
Phone #:	Position:	Salary:	
Employed from:	to		
Responsibilities:			
Reason for Leaving:			
May we Contact:	Yes	No	Contact Person:

Employer:	Address:	
Phone #:	Position:	Salary:
Employed from:	to	
Responsibilities:		
Reason for Leaving:		
May we Contact:	Yes	No Contact Person:

Employer:	Address:	
Phone #:	Position:	Salary:
Employed from:	to	
Responsibilities:		
Reason for Leaving:		
May we Contact:	Yes	No Contact Person:

I hereby certify that the information on this application, on my resume, and in my interviews contains no willful misrepresentations or falsifications and that the information given by me is correct, and complete to the best of my knowledge, and belief. I understand that if I am hired, any false or misleading statement, falsification, or omission of material fact, whenever or however discovered, may lead to discipline up to and including termination. I also authorize Community Care (CARE) to verify all statements contained in this application and to make any necessary job related reference checks.

I authorize the employers, supervisors, and references provided or discovered during my application process to give CARE any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for damage or injury that may result from furnishing same to CARE.

In consideration of my employment, I agree to the rules and regulations of CARE, and my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, at the option of either CARE or myself. I understand that no manager or representative of the company, other than the executive director, has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing. I understand that nothing contained in this application or that any policy, practice or procedure of the company creates a contract between the company and me for either employment or for the providing of any benefits."

I understand that an offer of employment is conditional based upon the results of a medical examination and background checks.

SIGNATURE

DATE



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AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

I, _____ give my permission to Community Care to complete a background check which includes requesting information from Child Protective Services – Department of Human Services, convictions data (criminal records search) from the State Bureau of Identification, driving and accident records from the Department of Motor Vehicles, reference checks from former employers and supervisors, professional references and other eligibility checks on all application and employees as needed. I understand that some of these records and background checks may be done through a nationwide automated employment screening service(s). These background checks are paid for by Community Care and not the applicant.

Community Care reserves the right to ask for this information due to Federal Medicaid Regulations, Department of Human Services, Department of Mental Health, Mental Retardation and Substance Abuse, and other state and federal laws and licensing regulation. Termination of employee or termination from the application process may result from information received as a result of the above mentioned background checks.

PLEASE PRINT ALL INFORMATION

 First Name Middle Name Last Name

 Other Names Previously Used or Known By

 Street Address Mailing Address (If Different from Street Address)

 City County State Zip

 Date of Birth Social Security Number

 Name of Current Spouse and/or Prior Spouse(s) if applicable

Other Cities, Countries & States you have resided in AND/OR you hold or have held a Drivers License in over the last five (5) years

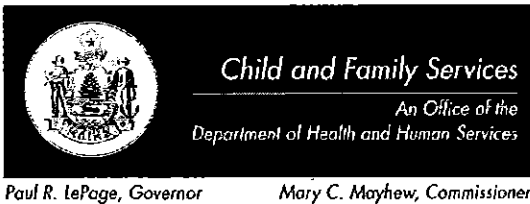
City	County	State	Dates Resided	Yes / No Held Driver's License	# _____ Driver's License Number	<input type="checkbox"/>
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City	County	State	Dates Resided	Yes / No Held Driver's License	# _____ Driver's License Number	<input type="checkbox"/>
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City	County	State	Dates Resided	Yes / No Held Driver's License	# _____ Driver's License Number	<input type="checkbox"/>
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City	County	State	Dates Resided	Yes / No Held Driver's License	# _____ Driver's License Number	<input type="checkbox"/>
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ME – MVR ME – SBI ME – CPS ME – Sex Offender Completed by: _____ Date: _____



Department of Health and Human Services
Child and Family Services
2 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel. (207) 624-7900
Fax (207) 287-5282; TTY (800) 606-0215

INITIAL RELEASE AUTHORIZATION FOR MAINE CHILD PROTECTIVE SERVICES CASE RECORDS RESEARCH

AGENCY ID#: 284

AGENCY NAME: Community Care

I, _____, authorize release of confidential information by the Maine Department of
(Please print clearly)
Health and Human Services, Office of Child and Family Services, regarding whether I have been involved in a
substantiated Maine Child Protective Services case.

Enclosed is the \$15.00 fee authorized under P.L. 2003, C. 673, Part W, payable to the Treasurer, State of Maine.

I understand that:

- a. If this search shows that I have been involved in a substantiated child protective case, another release by me is required before the nature of my involvement will be disclosed to the agency/service provider identified below.
- b. This information will be used as part of the agency/service provider's assessment of my suitability to provide services for children, adults, and families for this agency.
- c. This information is subject to continuing confidentiality as provided by Maine statutes Title 22 §4008.

This consent will expire upon the release of the information as authorized.

This consent may be revoked by me in writing at any time, except for information that has already been released.

Agency/Provider to receive this information:

Jennifer Baker
Community Care
P.O. Box 936
Bangor, ME 04402

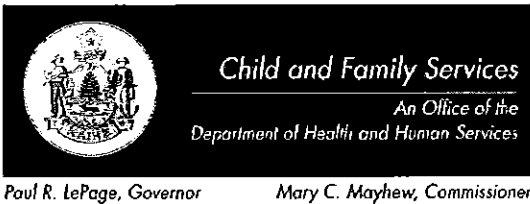
My date of birth: _____
(Confidentiality laws prohibit providing information on individuals under 18.)

Other names known by, including maiden.

Signature (subject of records research) Date

Address

This form should be completed by the individual who is the subject of the child protective records research request. This form should accompany the 083 Findings Form. Please include a self-addressed postage paid return envelope and a check/money order for the fee(s) of \$15.00 per person, payable to the Treasurer State of Maine. Please mail your requests to DHHS, Child Protective Intake, Records Research, SHS 11, 2 Anthony Avenue, Augusta, ME 04333. For questions please call 1-800-452-1999 x2.



Child and Family Services

An Office of the
Department of Health and Human Services

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
Child and Family Services
2 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel. (207) 624-7900
Fax (207) 287-5282; TTY (800) 606-0215

Agency ID#: 284

Jennifer Baker
Community Care
P.O. Box 936
Bangor, ME 04402

1. Name of Subject of child protective records research: _____
2. Date of Birth: _____
3. Others names known by: _____
4. Today's Date: _____

Only the above four lines of this form should be completed by the individual who is the subject of this child protective records research request. This form should accompany the completed Initial Release 082 Form.

You provided us with a release of information signed by the person named above. You requested a child abuse/neglect screening regarding this person. You included the \$15.00 fee per person, payable to the Treasurer, State of Maine.

This search has several limitations. Only allegations of child abuse or neglect that were substantiated are included. Reports or requests for services referred out to other resources are not included. Allegations that were unsubstantiated or indicated are not included. Persons involved in a case with different last names may be missed by the search process. Therefore, a negative response to a search should not be construed as a guarantee that this person has never been involved with Maine Child Protective Services.

Research of our child protective case records file found that:

- This person was not involved in a substantiated child protection case.
- Research of our child protective case records found that this person was involved in a substantiated child protection case. Before we can provide information about the nature of this person's involvement, we will need a subsequent release. This must be on the Department's (OCFSCP-084) Secondary Release Form (***COPY ENCLOSED***) to authorize release of confidential child protective services case records information.
- The above named person is under 18 years of age. Confidentiality laws prohibit providing information on children under 18.

This information is being provided to you solely for the purpose identified in the signed release and is subject to continuing confidentiality as provided by Maine statutes Title 22 section §4008. Any unlawful dissemination is a class E Crime, punishable by a fine of not more than \$500.00 or by imprisonment for not more than 30 days.

If you have any questions about this information please call 1-800-452-1999 x2.

Sincerely,

Child Protective Intake Unit

OCFSCP-083 Findings Form
Updated 3/24/11