We appreciate your interest in New Horizons Professional Services. Enclosed in the employment package is documentation required for consideration of employment.

Please read all the information thoroughly and complete all the paperwork included in the packet before returning it to the office for processing.

This packet includes:

1) An application that must be completed, dated, and signed
2) A background check release form
3) 3 Reference forms—Two must be Professional: One can be personal
4) A Preference Assessment

All forms must be filled out completely and signed upon return.

Bring with you when you return your packet a copy of the following:

1) Proof of Education (High School Diploma, GED, or official transcripts for proof of graduation from high school)
2) Current Driver's License or picture identification
3) Social Security Card or Birth Certificate
4) Auto Registration and Insurance

New Horizons training program includes NCI Training, Medication Administration, OSHA, CPR, First Aid, Documentation and other required company trainings. Please note **all new hires are required to complete the company provided training program.** We do not accept trainings obtained at other agencies or programs.

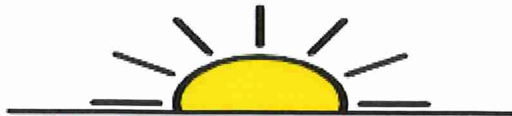
Once again, thank you for your interest in our company. We hope to hear from you soon.

Thank you

Human Resources

P.S. YOUR INTERVIEW WILL NOT BE SCHEDULED UNTIL ALL DOCUMENTATION IS COMPLETED AND/OR OBTAINED. PLEASE READ CAREFULLY AS NO EXCEPTIONS SHALL BE MADE.

1 Centerview Dr Suite 215 Greensboro, NC 27407 Ph:336-285-8002 Fax: 336-285-8670



Employment Application

Date:______________

Applicant Information

Full Name: ____ DOB: ____________

Last *First* *M.I.*

Address: ____

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Phone: ______________________ Email ______________________

Date Available: __________ Social Security No.: __________ Desired Salary:$ __________

Referred by: ____

Position Applied For:

☐ Direct Care Staff ☐ Day Support Staff ☐ Community Networking ☐ AFL

☐ Supportive Employment ☐ Personal Care Services ☐ In-Home Skill Building

☐ Respite ☐ Supervised Living ☐ Other:______________________________

Are you a U.S. citizen? Yes ☐ No ☐ If no, are you authorized to work in the U.S.?_____

Have you ever worked for the company? Yes ☐ No ☐ If yes, when?________________

Have you ever been convicted of a felony? Yes ☐ No ☐

If yes, please explain:

____

____

____

Education

High School:________________ Address:________________

From:________ To:________ Did you graduate? Yes ☐ No ☐ Diploma:________

College:________________ Address:________________

From:________ To:________ Did you graduate? Yes ☐ No ☐ Degree:________

Other:________________ Address:________________

From:________ To:________ Did you graduate? Yes ☐ No ☐ Degree:________

References

Full Name:________________ Address:________________

From:________ To:________ Did you graduate? Yes ☐ No ☐
Degree:________

Full Name:________________ Address:________________

From:________ To:________ Did you graduate? Yes ☐ No ☐
Degree:________

Full Name:________________ Address:________________

From:________ To:________ Did you graduate? Yes ☐ No ☐
Degree:________

Previous Employment

Company:________________ Phone:________

Address:________________ Supervisor:________

________________ ________

Job Title: Starting Salary: Ending Salary:

Responsibilities ________________

From:________ To:________ Reason for Leaving:________

May we contact your previous supervisor for a eference? Yes ☐ \o ☐

Company: ______ Phone: ______

Address: ______ Supervisor: ______

Job Title: Starting Salary: Ending Salary:

Responsibilities ______

From: ______ To: ______ Reason for Leaving: ______

May we contact your previous supervisor for a eference? ☐ Yes ☐ \lo

Company: ______ Phone: ______

Address: ______ Supervisor: ______

Job Title: Starting Salary: Ending Salary:

Responsibilities ______

From: ______ To: ______ Reason for Leaving: ______

May we contact your previous supervisor for a eference? ☐ Yes ☐ \lo

Military Service

Branch: ______ From: ______ To: ______

Rank at Discharge: ______ Type of Discharge: ______

If other than honorable, explain: ______

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: ______________________ Date: __________

Preference Assessment

1) Why are you interested in Alternative Family Living (AFL) or Group Home Living?

2) What are some of your strengths?

3) What are some of areas you would consider you need improvement?

4) What are the dynamics of your household?

5) Would you be able to work well with an individual in a wheelchair?

6) Would you work well with an individual that has incontinence?

7) What are somethings you do for entertainment?

8) Would you have secondary employment? Yes/NO

9) Would you work well with an individual who did not have day program, day treatment or school services?

10) What type of community engagement activities would you be interested in completing with a individual?

11) What are behaviors that you would not be able to cope with from a individual?

12) Is your home fully accessible for a individual?

13) Would you consider yourself to work best with ambulatory or individual with a special handicap?

14) Do you understand individuals are to have privacy in their sleeping or living unit?

15) Do you understand if an individual will be sharing a room, they have a choice of their roommate?

16) Do you understand that individuals are free to have visitors?

17) Do you understand individuals are free to decorate their sleeping and living units?

18) Do you understand staff is not to use drugs which include marijuana?

19) Would you be interested in fulfilling any of the following job descriptions?

- **Crisis Services**

Crisis Services provide one additional staff person who is trained in behavior techniques, the participant's person-centered plan and the crisis plan, to provide services for the participant, as needed, during an acute crisis situation so that the participant can continue in his/her daily routine and/or residential setting without interruption.

Yes___No___

- **Day Supports**

Day supports provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, which take place in a licensed non-residential setting, separate from the home or facility in which the participant resides.
Day supports shall focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the Individual Support Plan (ISP). In addition, habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.
This service meets the day programming needs of participants who choose to attend or receive services provided by a licensed facility, such as an adult day vocational program (ADVP) or Developmental Day.
Community activities that originate from a licensed day facility will be provided and billed as Day Supports. On-site attendance at the licensed facility is not required to receive services that originate from the facility.
Day support may include prevocational activities. The following criteria differentiate between prevocational and vocational services.
Prevocational Service is provided to persons who are not expected to join the general work force or participate in a transitional sheltered workshop within one year of service initiation.
If compensated, individuals are paid less than 50% of the minimum wage.
Services include activities that are not directed at teaching job-specific skills but at underlying habilitative goals (attention span, motor skills, attendance, and task completion).
Day Supports may not be used for the provisional of vocational services (sheltered work performed in a facility).

Yes___No___

- **Community Networking**

Community Networking is an individualized service that supports the participant's definition of a meaningful day in a community setting with non-disabled individuals. The purpose is to develop natural support within integrated settings.

Yes___No___

- **Residential Supports**

Residential Supports is provided to adults and children residing in a licensed or unlicensed facility. Except, Residential Supports services provided to recipients under the age of 18 years old shall be provided in a licensed facility only. The level of intensity of the service is based on levels 1 -5. The level shall be determined by the individual's Support Intensity Scale (SIS).
Residential Supports provided in Alternative Family Living (AFL) sites must be the primary residence of the AFL provider, which may include couples or individuals. AFLs may be licensed or unlicensed.
Residential Supports provided in licensed facilities or group homes must demonstrate a home and community character. They are expected to be located in residential neighborhoods in the community.
A home and community environment is characterized as an environment like a home, provides full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, provides for privacy, visitors at times convenient to the participant and easy access to resources and activities in the community. Meals may be served family style, have the potential participate in employment, schools or day programs. Each facility shall assure to each participant the right to live as normally as possible while receiving care and treatment.

Yes___No___

- **Personal Care Services/Personal Assistance**

Personal Care services provide support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living. Support and engaging the participant's involvement is non-habilitative and describes the flexibility of activities that may encourage the participant to maintain skills gained during active treatment and/or habilitation, while also providing supervision for independent activities of the participant. This service may include preparation of meals but does not include the cost of the meals themselves. Engaging the participant in utilizing skills gained during active treatment and/or habilitation is key and may be provided outside of the individual's residence during community activities.

When specified in the Person-Centered Plan, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care provided, or which are essential to the health and welfare of the participant, rather than the participants' family. Personal Care also includes assistance with monitoring the health status and physical condition, assistance with transferring, ambulation and the use of special mobility devices.

Yes___No___

- **Respite**

Respite is a service that provides periodic relief for the family or primary caregiver as detailed in the approved Person-Centered Plan. In order to be considered the primary care giver, a person must be principally responsible for the care and supervision of the participant and must maintain their primary residence at the same address as the covered participant. This service may be provided in the participant's home or in an out-of-home setting. There must be clear justification outlined within the Person-Centered Plan for Respite Services. Specified training requirements for direct care staff must be clearly documented within the Person-Centered Plan for the task that will be performed for Respite services.

Non-institutional Respite is either Individual or in a Group Setting and is provided in the community and not at a State Developmental Center.

Yes___No___

- **Supervised Living**

Supervised Living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in a residence.

Yes___No___

- **In-Home Skill Building**

In-Home Skill Building (IHSB) provides habilitation and skill building to enable the participant to acquire and maintain skills, which support more independence. IHSB augments the family and natural supports of the participant and consists of an array of services that are required to maintain and assist the participant to live in community settings. IHSB consists of training in interpersonal skills and development and maintenance of personal relationships. It supports the participant in increasing community living skills, such as shopping, recreation, personal banking, grocery shopping and other community activities. Training with therapeutic exercises, supervision of self-administration of medication and other services

essential to healthcare at home, including transferring, ambulation and use of special mobility devices.
Transportation is included to support the implementation of IHSB.
Other key components of IHSB are:
Services may be provided when the primary caregiver is present or away from home.

Service is individualized to the participant's specific needs.

It is anticipated there will be a gradual reduction in hours as the participant is able to master certain skills.

IHSB is provided in the participant's private home and the service must start and end at the home.

Yes___No___

- **Supportive Employment**

Supportive Employment (SE) provides assistance with choosing/matching, acquiring/finding, development and initial job training for participants ages 16 and older for whom competitive employment has not been achieved and or has been interrupted or intermittent. A transition plan will be included in the ISP to alleviate the reliance on SE to move toward utilization of Long-Term Vocational Supports.
SE includes pre-job training/education and development activities to prepare a participant to engage in meaningful work-related activities which may include but not limited to:
Career/educational counseling
Job shadowing
Assistance in the use of educational resources
Training in resume preparation
Job interview skills
Study skills
Assistance in the job tasks and learning skills necessary for job retention
Assistance to develop and operate a Micro-Enterprise

Yes___No___

To Whom It May Concern:

______________________________________ has applied for employment with our company. This is a reference form we would like you to complete. Please mail it to us or return it to the applicant in a sealed envelope. You may also return by fax if you wish.

I would appreciate your answering the following questions about the applicant:

In what capacity do you know the applicant? ______________________________________

If a co-worker, what was the last position held at your company? ____________________

Please check the most appropriate response to the following:

	Outstanding	Good	Average	Fair	Poor
Knowledge of Job					
Ability to work with others					
Reliability					
Drive/Motivation					
Sense of company loyalty					
Overall competence					

Is there anything else you would like to add?
____
____

Name of Reference: __________________________________ Daytime Phone: ___________________

Signature of Reference: ________________________________ Date: ____________________________

I assure you that any information you supply about this applicant will be held in strict confidence. If there is ever an opportunity for me to reciprocate, I will be please to do so. Thank you.

To Whom It May Concern:

_____________________________________ has applied for employment with our company. This is a reference form we would like you to complete. Please mail it to us or return it to the applicant in a sealed envelope. You may also return by fax if you wish.

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	Outstanding	Good	Average	Fair	Poor
Knowledge of Job					
Ability to work with others					
Reliability					
Drive/Motivation					
Sense of company loyalty					
Overall competence					

Is there anything else you would like to add?

____

____

Name of Reference: __________________________________ Daytime Phone: ___________________

Signature of Reference: ________________________________ Date: ___________________________

I assure you that any information you supply about this applicant will be held in strict confidence. If there is ever an opportunity for me to reciprocate, I will be please to do so. Thank you.

1 Centerview Dr Suite 215 Greensboro NC 27407 Ph:336-285-8002 Fax:336-285-8670

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Knowledge of Job					
Ability to work with others					
Reliability					
Drive/Motivation					
Sense of company loyalty					
Overall competence					

Is there anything else you would like to add?

____

____

Name of Reference: _________________________________ Daytime Phone: ___________________

Signature of Reference: _______________________________ Date: ___________________________

I assure you that any information you supply about this applicant will be held in strict confidence. If there is ever an opportunity for me to reciprocate, I will be please to do so. Thank you.

1 Centerview Dr Suite 215 Greensboro NC 27407 Ph:336-285-8002 Fax:336-285-8670

CONFIDENTIAL

Background Check Authorization

Print Name: ____

(First) (Middle) (Last)

Former Name(s) and Dates Used: ______________________________

Current Address Since: ______________________________________

(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: ______________________________________

(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: ______________________________________

(Mo/Yr) (Street) (City) (Zip/State)

Social Security Number: ______________________ DOB: __________

Telephone Number: ____

Drivers License Number/State: _________________________________

The information contained in this application is correct to the best of my knowledge.

I hereby authorize ______________________________ and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to ____________________________ or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. ____________________________ and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: __________________________________ Date: ______________

Notice to California, Minnesota and Oklahoma Residents:
Please check the box below if you wish to receive a copy of a consumer report that is requested.
☐ I wish to receive a copy of any Background Check Report on me that is requested.