Developmental Disabilities Resources, Inc.
9822 Albemarle Road
Charlotte, NC 28227
Phone: 704-573-9777 Fax: 704-545-2219

Dear Potential Service Provider:

Thank you for your interest in becoming a provider for people served through DDR, Inc. We offer the following services:

CAP-MR/DD
Residential Supports
Home and Community Supports
Personal Care
Home Supports
Respite
Individual Caregiver Training and Education
Day Supports

State Funded Services
Developmental Therapy
Personal Assistance
Respite
Crisis Respite
Family Living

NC Innovation Services
Residential Supports
In-Home Skill Building
Personal Care Services
In-Home Intensive Supports
Respite
B-3 Respite
Community Networking

To become a service provider, there are some classes required by DDR, Inc. prior to beginning services. DDR provides training in our office by qualified staff at no cost to our providers. We will also accept approved authentic certificates from qualified agencies for the following: First Aid, CPR & NCI A, B and B+.

As a service provider for DDR, Inc., you will be considered an independent contractor and not an employee. You will be given a 1099 unless you provide residential services for us. The state of North Carolina requires that each provider have a criminal background check done for a period of the last five years. DDR also runs the following checks: Health Care Registry, DMV, and Sex Offender Registry. There is a release in the application packet that must be signed so that we may have this completed prior to your beginning services. If you have any questions about the application process or need further assistance, please feel free to contact our office at 704-573-9777.

Thank you again for your interest in serving people through DDR, Inc.

Sincerely,
Sandy Hiton
Family Service Coordinator

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Documents required prior to providing services:

- Valid Driver's License (North Carolina Driver's license is required for some services)
- Social Security Card
- Copy of High School Diploma or GED
- Auto Insurance – copy of declarations page
- Driving record check (DDR obtains this with signed release)
- Criminal Background Check (DDR obtains with your signed release)
- Doctor's statement of good general health
- TB risk assessment form, TB test or Chest X-Ray
- Homeowners/renters Insurance – copy of declarations page (If consumer will be in your home)

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Training and Orientation Requirements

These training sessions are provided in our office by individuals privileged to train direct care staff. These trainings are offered in a comfortable, non-threatening environment. Certificates from authorized training facilities will be accepted for CPR & First Aid and NCI A, B & B+ only.

- ❑ CPR
- ❑ First Aid
- ❑ Medication administration (not injections)
- ❑ NCI A (NCI B and B+ may be required depending on the consumer's needs)
- ❑ Blood borne Pathogens
- ❑ Elements for Incident/Accident and Other Reportable Events
- ❑ Elements for Core Values
- ❑ Elements for Overview of Developmental Disabilities
- ❑ Elements for Interaction and Communication Competencies
- ❑ Elements for Participant Rights
- ❑ Elements for Person Centered Thinking
- ❑ Elements for Role/Purpose/Philosophy of Services
- ❑ Elements for Service and Documentation
- ❑ Client Specific Competency
- ❑ Diversity
- ❑ Emergency Procedures
- ❑ Agency Orientation

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Application

1. Name: ____
(Last) (First) (Middle/Maiden)

Date of Birth: ____________________ Place of Birth: ______________________

Social Security Number: ____
(Copy also required.)

2. Address: ____
(Street)

____
(City/State/Zip)

Phone: (_____)_______________ Other Number:(_____)_______________

Email address:____

Times available to provide services:

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

3. Other Members of Household:

Name	Date of Birth	Relationship to Applicant	Place of Employment

4. Will you be able to provide a client with his/her private bedroom? ______________________
****This is a requirement for overnight placements such as respite or residential homes.****

5. List any health/medical limitations (DDR does not discriminate on the basis of disabilities however; we will need to know if you have any limitations such as lifting etc.)
**** North Carolina requires an annual statement of good overall health from a doctor****

____

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6. Drivers License Number: ________________________ (Copy required)
****Drivers license required by the state in which you live****

7. Do you have a high school diploma or GED?__________ (Copy required)
****Valid High School Diploma or GED required to provide services****

8. How did you learn about DDR?
____

Referred by:____

9. What do you have to offer an individual with developmental disabilities? _______________
____
____

10. Are you proficient in any other languages? Please circle Spanish Vietnamese

Chinese Japanese Other:__________________

11. Do you know sign language? ________ If so what type?______________________

12. Are you employed outside the home? _____ If so where? ______________________

Working days and hours: ____

Work Phone Number: (_____)_______________________

Can you be contacted at work by DDR if necessary?_______

13. References****Must list at least 2 references****
BUSINESS
Business Name: ____
Contact Person: ____
Address: ____
Telephone Number: (_____)____
Verified By:____

PERSONAL
Name: ____
Address: ____
Telephone Number: (____)____
Verified By:____

14. Have you ever been convicted of a felony or a crime other than a misdemeanor? ______
****Criminal background check required prior to provision of services****

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15. Are you willing to participate in training sessions? ___________________________
    ****Annual training sessions are required for all service providers****

16. **Job Experience**

****You must have 1 year of experience in the field of intellectual/developmental disabilities to provide services****

Please list job experience

Business Name	Address	Phone Number and Contact Person	Dates of Employment	Position	Salary	Experience Verification Office Use

The information that I have provided is accurate and correct to the best of my knowledge. I, the undersigned hereby acknowledge that I am not an employee of Developmental Disabilities Resources, Inc. and that my status with the company is that of an independent contractor. In acting as a caregiver, I acknowledge that all state and federal income taxes including federal social security taxes are my sole responsibility and not that of Developmental Disabilities Resources, Inc.

____ ______________________
Signed **Date**

FOR RESIDENTIAL PLACEMENTS ONLY

Is your home currently licensed? _______________ License Expires: _______________

Fire/Safety Inspection? Date: ________________________

Hard Wired Smoke Detectors installed? ____________________________

Fire extinguisher? ____________________________

Sanitation Inspection? Date: _______________________

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Release of Information Consent for Criminal History, Health Care Registry, Sex Offender & DMV Record Checks

I, ______________________________, give DDR, Inc consent for a criminal history record check, Health Care Registry Check, Division of Motor Vehicle check as required in the NC General Statute, as well as a sex offender registry check through watchdog.com. I understand that if DDR, Inc disqualifies me after consideration of the relevant factors, DDR may disclose information to me contained in the record check that is relevant to my disqualification, but may not provide a copy of the criminal history record or motor vehicle check to me.

____ ____________________
Signature of care provider Date

____ ____________________
Signature of DDR, Inc witness Date

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TB and Communicable Disease Questionnaire

Care Provider Name:_______________ Date:__________

TB Risk Assessment	Yes	No	Don't Know
Do You Have:			
1 Close Contact with anyone who has tuberculosis?			
2. Any of these medical conditions?			
a. History of TB			
b. HIV infection			
c. Diabetes mellitus			
d. High doses of steroids/immunosuppressive therapy			
e. Chronic renal failure			
f. Leukemia/lymphoma			
g. Severely underweight			
3. Close contact with anyone who has arrived within 5 years from Africa, Asia, Latin America, or the Middle East?			
4. Close contact with anyone who is:			
a. HIV positive			
b. Homeless			
c. An IV drug user			
d. A migrant worker			
e. Employed by or resides at a correctional facility, homeless shelter, long term facility			
Have you had any close contact to anyone with known communicable diseases?			
Explain any "yes" or "don't know" answers to the above.			

I, _________________________, do fully acknowledge that I am in good physical health and can perform all duties as set forth in my job description. If at any time my health status changes, I will inform DDR.

Care Provider Signature:___________________________Date:_______________

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Acknowledgment of Confidentiality

In connection with my activities as ___________________________, I agree to hold all information that I may have access to about clients or former clients confidential and will not divulge any information to unauthorized persons. I understand that the divulging of confidential information to unauthorized persons will make me subject to either civil action for the collection of monetary damages and/or suspension of dismissal.

I have been informed regarding the liability of persons with access to client information, as follows:

1. Disclosure of confidential information to persons not authorized to receive such information during or after my service as a care provider can result in prosecution and a fine of or up to $500.00. (G.S. 122C-52(e)).

2. Violation of any of the federal regulations relating to Confidentiality of Alcohol and Drug Abuse Patient Records may result in a fine of up to $500.00 for a first offense and up to $5,000.00 for a subsequent offense. (Title 42- Public Health, Chapter2, Subpart A, 408, 2 (f)).

3. Failure to comply with the confidentiality regulations (10 – NCAC 18D, APSM 45 –1) and N.C. General Statutes 122C – 51 through 56 and the Federal Regulations (42 – CRR, Part 2) can be grounds for immediate termination of care provider status.

_____________________________ ____________
Care Provider Signature Date

_____________________________ ____________
DDR Staff Signature Date

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