AFC CAREGIVER APPLICATION

Please note, when emailing make sure to enter *ENCRYPT:* (the word encrypt with a colon after it) in the subject line before entering your subject. This will protect your personal information from hackers.

Subject ENCRYPT:

PLEASE COMPLETE THE ENCLOSED PAPER WORK AND RETURN WITH THE REQUIRED DOCUMENTS (clear photocopy of license) TO MY ATTENTION @ Fax # 978-313-6664,
BY EMAIL @ LCOUTTS@TEMPUSUNLIMITED.ORG, OR DROP IN THE MAIL TO THE ADDRESS LISTED BELOW, TO MY ATTENTION.

THANK YOU,

LYNNE COUTTS
TEMPUS UNLIMITED AFC PROGRAM
PH# 781-297-5566
FAX# 978-313-6664

AFC Caregiver Paperwork Instructions

1. **Application** - You MUST fill out all information requested. All questions regarding the type of home and who lives there should be filled out based on the current home and family situation. For backup caregivers, just fill out the questions based on the home the person you will be caring for.
2. **Background Check –** ***The CORI Background Check must be completed in full,*** with all of your information. Send a clear, legible copy of your license as well.
3. **Verification Documents –** To qualify as a caregiver, you must provide documents to verify your identification and proof of address. Please see the checklist provided for all examples of documentation accepted.

Once you have completed all the requirements of the application packet, you can either give it to the Case Manager at the Orientation, mail or fax it to:

Tempus Unlimited Inc.
AFC/Community Services
600 Technology Center Drive
Stoughton, MA 02072
Fax # 978-313-6664

*Once all the paperwork is received, an AFC staff member will call your references provided and send for your CORI, SORI, and OIG checks to be completed.

Please note, when emailing make sure to enter *ENCRYPT:* (the word encrypt with a colon after it) in the subject line before entering your subject. This will protect your personal information from hackers.

600 Technology Center Drive Stoughton, MA 02072
(800) 924-7570 Fax (978) 313- 6664

ADULT FOSTER CARE
CAREGIVER APPLICATION

Date:_____

Name:_____ Social Security Number_____

Address:_____

Email: _____

Please check which of these best describes you living situation

Own Home:_____ Rent Home:____ Rent Apartment:_____ Other (explain):_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Best time to Contact:_____

Are you legally eligible to work in the United States:_____

Caregiver approval is subject to verification of your eligibility to work in the United States.

Are you over 18 years old:_____Do you have a valid Driver's License: _____

Do you own your own vehicle or a vehicle you share: _____

If yes, please present to AFC staff a valid Driver's License, Registration and proof of car insurance.

If you do not own a vehicle please explain your primary means of accessing reliable transportation:

_____

_____

_____

Have you ever applied for any position with Tempus Unlimited?: _____

If yes, what was the date and position you applied for:_____

Are you now or have you ever acted as a Caregiver in an AFC or Shared Living program:_____

If Yes, please provides program name and dates you were active:_____

If Yes and the placement has ended, what was the reason:_____

Is anyone in your home receiving Adult Foster Care, Shared Living, Personal Care Attendant, Hospice, Visiting Nurse, Homemaking, Elder Services or any other state funded or MassHealth/ Medicare funded services:_____

If Yes, please explain all services being provided:

_____

_____

_____

Please list all people who live in your home or whom regularly spend time in your home

Name:	DOB:	Live in a home?	Occupation:	Relationship to you

If you are unavailable is there anyone else in your home capable of providing care:_____

If yes, who_____

If you, how do you plan to ensure care is provided if you are unavailable:

_____

Please list all experience you've had caring for anyone with a disability:

_____

_____

_____

What interests you about being a Caregiver in an Adult Foster Care Program?

_____

_____

What are you most hoping to get out of this program?

_____

_____

Are you able to perform all the essential duties as identified in the Caregiver Responsibilities and Caregiver Qualifications sections of your AFC Orientation packet? Please explain yes or no:

_____

_____

_____

EDUCATIONAL HISTORY

Do you have a high school diploma or GED? Please specify:_____

Did you attend any institute of higher learning:_____ Did you receive a degree: _____

If yes, please give the name of the college you attended, the degree you received and your year of graduation:

_____

_____

WORK HISTORY- Please list your previous three employers starting with your most recent employer

Company Name:_____ Start Date:_____ End Date:_____

Company Address:_____Supervisor name: _____

Position(s) held:_____Supervisor phone: _____

Reason for leaving:_____May we contact: _____

Company Name:_____Start Date:_____End Date:_____

Company Address: _____Supervisor name:_____

Position(s) held:_____Supervisor phone:_____

Reason for leaving:_____May we contact:_____

Company Name:_____Start Date:_____End Date:_____

Company Address:_____Supervisor name:_____

Position(s) held:_____Supervisor phone:_____

Reason for leaving:_____May we contact:_____

Please explain any gaps in your work experience or any reason for less than 5 years of work experience:

_____

_____

_____

_____

If approved as a Caregiver, how many years would be plan on staying the role. Please provide an explanation:

_____

_____

_____

_____

REFERENCES

In order to be approved as a Caregiver in the Community Services Adult Foster Care program you must have a medical reference and two other references, either personal or professional. Your medical reference must come from a Primary Care Physician. Family members cannot be used as a reference

Primary Care Provider: _____

How long have you been with this provider? _____

Address:_____ Phone:_____

_____ Fax:_____

Personal/ Professional Reference Name:_____

Relationship to you_____ Years known:_____

Address:_____ Home Phone:_____

_____ Cell Phone:_____

Personal/ Professional Reference Name:_____

Relationship to you_____ Years known:_____

Address:_____ Home Phone:_____

_____ Cell Phone:_____

Is there anything else you want us to know about you:

_____

_____

_____

_____

_____

**********OFFICE USE ONLY- DO NOT WRITE BELOW THIS LINE**********

Date received:_____ Received by_____

Date Reviewed:_____ Approved (Yes or No)_____

Approved by:_____ Signature:_____

Reason not approved:_____

Follow up if not approved:

_____

_____

CAREGIVER DOCUMENTS CHECKLIST: Caregiver approval requires you present the following documents with your application to ensure it is processed in a timely manner. If the application is mailed or faxed in, please be prepared to display the documents to AFC staff at the home visit.

****For Primary Caregivers no documents will be accepted with an address other than the Qualified Setting****

Documents to establish Identity: Please present the following: Dependent on the document only one may be required (passport, permanent resident card)

_____ Mass Driver's License _____Mass ID Card _____US Military ID _____US Passport

_____Permanent Resident Card _____ Social Security Card

Documents to establish eligibility to provide transportation: All are required

_____ Mass Driver's License _____ Proof of Car Insurance _____ Vehicle Registration

Documents to establish proof of residence: Please present at least 2 documents. No document may be more that 60 days old

_____Utility Bill, Cell Phone Bill, Credit Card Bill, Medical Bill _____Bank Statement

_____ Canceled Check _____ Pay Stub _____Medicare/ Medicaid Correspondence

If you or a family member owns the home you live in:

_____ Proof of Home Owner's Insurance

If your home is rented: Must submit both

_____ Proof of the current lease listing both Member and Caregiver as residents or written notification from the homeowner stating they are aware both Member and Caregiver are residing in the home

_____Proof of Rental Insurance

- **Please note: the AFC Program does not collect copies or images of any required documents noted above. Please be prepared to show these documents to the AFC staff.**

Thank you

TEMPUS UNLIMITED, INC.
Opportunities for Independence
formerly Cerebral Palsy of Massachusetts, Inc.

Dear Caregiver,

Per MassHealth regulations, we are required to run your background check, along with anyone 18 years and over, that lives in your home (except the member). Enclosed are background check forms for you to complete.

Please make sure you sign the first page, then fill out the second page to the "**STOP**" sign. If you need more forms, please call.

For everyone that filled out the form, we will need a clear copy of their state identification, driver's license, or passport. If you cannot make or send a copy, please contact your Case Manager and they will go through the current method of accommodation we have in place due to COVID19.

Please return the completed forms with copies of the ID's to me at the address listed on the bottom or via fax. If mailing these documents, please write "AFC PROGRAM" on the front of the envelope, so that they are forwarded to the correct department at Tempus.

If you have any questions, please feel free to let me know.

Thank you,

LYNNE COUTTS
TEMPUS UNLIMITED AFC PROGRAM
PH# 781-297-5566
FAX# 978-313-6664

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services 200
Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS

This form is not to be faxed. Please return form to organization .

Criminal Offender Record Information (CORI) Acknowledgement Form

To be used by organizations conducting CORI checks for employment or licensing purposes.

_____ is registered under the
(Organization)
provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, or current licensees.

As a prospective or current employee, subcontractor, volunteer, license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to

_____
(Organization)
to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing _____
(Organization)

with written notice of my intent to withdraw consent to a CORI check.

I also understand, that _____may conduct
(Organization)
subsequent CORI checks within one year of the date this Form was signed by me.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____

Signature of CORI Subject *Date*

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS

SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: ___ ___ -- ___ ___ ___ ___ ☐ No Social Security Number

Sex: _____ Height: _____ ft. _____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

STOP **SUBJECT VERIFICATION** STOP

The above information was verified by reviewing the following form(s) of government-issued identification:

_____

_____

_____

Verified by:

_____
Print Name of Verifying Employee

_____ _____
Signature of Verifying Employee *Date*