



## Direct Support Professional Application for Employment

### ***Applicant Information***

<b>Applicant Name:</b>	<b>Date:</b>
<b>Address:</b>	<b>City, Zip Code:</b>
<b>Email:</b>	<b>Phone:</b>
<b>Preferred Pronoun:</b>	<b>He/Him    She/Her    They/Them</b>
<b>Have you previously worked for Absolute HCBS?</b>	<b>Yes            No</b>
<b>Can you pass a background check?</b>	<b>Yes            No</b>

### ***Experience***

*A minimum of 3 months of experience and/or education in the field of developmental disabilities or a related field (volunteering, personal or professional) is required.*

If you have worked professionally as a Direct Support Professional previously or independently through the Division of Developmental Disabilities, please complete the following:

Agency Name	Start Date & End Date	Supervisor Name	Supervisor Phone & Email

I do not have experience as a Direct Support Professional.

If you have education, experience living with or experience volunteering with persons with developmental disabilities, please complete the following:

Type of Experience	Start Date & End Date	Name of Program (if applicable)	Contact for Verification Phone & Email

- I do not have education, experience living with, or experience volunteering with persons with developmental disabilities.

If you have teaching experience of any kind (certified teacher, paraprofessional, Sunday school teacher, tutor, swim teacher, etc.), please complete the following:

Type of Experience	Start Date & End Date	Supervisor Name	Supervisor Phone & Email

- I do not have any teaching experience.

Please check any of the following certifications, training, or education currently held:

- CPR
- First Aid
- Article IX
- Habilitation
- Prevention & Support
- Fingerprint Clearance Card
- Other \_\_\_\_\_

**References**

*Please list two professional and one personal reference. References may not be family members. References will be contacted and verified before the applicant can move forward in the hiring process. Please notify all listed references that Absolute HCBS will be contacting them.*

Reference Name	Reference Email (Required)	Reference Phone (Required)

If you are applying to work with a specific client at Absolute HCBS, please provide the following information:

Client First Name	Guardian Name	Guardian Phone
<b>Is this client a family member?</b> <b>Yes</b> <b>No</b>	<b>If yes, what is your relation?</b>	

Where did you hear about our agency? Please list the name of the person who referred you if applicable.

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**Please read carefully before signing.**

I understand that neither the completion of this application nor any other part of my consideration for employment establishes any obligation for Absolute HCBS to hire me. If I am hired, I understand that either Absolute HCBS or I can terminate my employment at any time and for any reason, with or without cause and without prior notice. I understand that no representative of Absolute HCBS has the authority to make any assurance to the contrary.

I attest with my signature below that I have given to Absolute HCBS true and complete information on this application. No requested information has been concealed. I authorize Absolute HCBS to contact references provided for employment reference checks. If any information I have provided is untrue, or if I have concealed material information, I understand that this will constitute cause for the denial of employment or immediate dismissal.

Date \_\_\_\_\_ Signature \_\_\_\_\_

**THIS APPLICATION IS VALID ONLY FOR 90 DAYS FROM THE DATE ABOVE.**