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| --- | --- |
| Bridges | Bridges is a for profit Sub-chapter S corporation |

**APPLICATION FOR EMPLOYMENT**

(Please print or type.)

We base all hiring decisions on nondiscriminatory factors without regard to race, color, gender, sexual orientation, religion, national origin, disability status, or status as a Vietnam-era veteran or special disabled veteran.

**Applicant Information:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | | | | | | | | **Date:** | | | |
| **Mailing Address:** | PO Box or Street | | | | City | | | State | | | ZIP |
| **Residential Address:** | Street | | | | City | | | State | | | Zip |
| **Phone:** |  | | | | **Alt. Phone:** | | | **Email:** | | | |
|  |  | | | | **Are you 18 or older?** | | Yes No  □ □ | **Are you 21 or older?** | Yes No  □ □ | | for Bridges’ vehicle insurance purposes |
| **Have you filed an application with Bridges before?** | | Yes No  □ □ | | | Date | |  | **Are you authorized to work in the US?** | | | Yes No  □ □ |
| **Do you have a valid Wyoming Driver’s license** | | Yes No  □ □ | | DL# | | | **How did you learn about Bridges?** | □ Walk-in  □ Newspaper □ Internet  □ Current employee:  *Name:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Former employee:  *Name:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Do any of your friends or relatives work for Bridges?** | | Yes No  □ □ | | | If YES, list names: | | | | | | |
| **Are any of your relatives a client of Bridges?** | | Yes No  □ □ | | | If YES, list relationship: | | | | | | |
| **Do you have a current CPR card?** | Yes No  □ □ | Exp date: | | | **Do you have a current First Aid Card?** | | Yes No  □ □ | Exp date: | |  |  |
| **Have you ever been certified for the Wyoming Home and Community Based Waiver Program and/or the Children’s Mental Health Waiver?** | | | Yes No  □ □ | | | **If Yes, Under what name and time period?** | | | | | |

**Background**

**Please see Wyoming Medicaid Rules, Chapter 45, section 25, part (a), (b), and (g) for background qualifications.**

1. **Have you ever been convicted of or plead “no contest” to an offense in a court of law? (Other than a minor traffic offense.)**

YES  NO

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Have you ever been substantiated for abuse or neglect by the Department of Family Services (DFS) or been convicted of or plead “no contest” to a misdemeanor or felony affecting another person’s health or safety in Wyoming or any other state?**

YES  NO

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Have you ever been sanctioned, debarred, suspended, excluded or convicted of or plead “no contest” to a criminal offense related to Medicare/Medicaid or any other State or Federal program?**

YES  NO

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By my signature I acknowledge that I have been truthful in my statements relating to any offenses I may have been charged and/or convicted of above.**

**Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Education**

**A certified or official transcript will be required upon hire**

|  |  |  |
| --- | --- | --- |
| **College:** | Name and Address of University or College: | Credits completed: \_\_\_\_\_\_  OR  Degree obtained: Yes No  Title of Degree: |
| **Graduate/Professional** | Name and Address of University or College: | Degree obtained: Yes No  Title of Degree: |
| **If no degree was obtained, describe your course of study:** |  | |

**Employment History**

(Document employment relevant to your Case Management qualifications and Human Services Experience)

***List most RECENT first.***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Employer:** | | | **Address:** | | **Phone:** | |
| **From:**  **\_\_\_/\_\_\_\_** | **To:**  **\_\_\_/\_\_\_\_** | | **Job title:** | | | |
| **Description of Duties:** | | | | | | |
| **Supervisor’s Name and Title:** | | | | **Starting wage:** | | **Ending wage:** |
| **May we contact for a reference?** | Yes No  □ □ | **Hours per week:** | |  | |  |
| **Reason for leaving:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Employer:** | | | **Address:** | | **Phone:** | |
| **From:**  **\_\_\_/\_\_\_\_** | **To:**  **\_\_\_/\_\_\_\_** | | **Job title:** | | | |
| **Description of Duties:** | | | | | | |
| **Supervisor’s Name and Title:** | | | | **Starting wage:** | | **Ending wage:** |
| **May we contact for a reference?** | Yes No  □ □ | **Hours per week:** | |  | |  |
| **Reason for leaving:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Employer:** | | | **Address:** | | **Phone:** | |
| **From:**  **\_\_\_/\_\_\_\_** | **To:**  **\_\_\_/\_\_\_\_** | | **Job title:** | | | |
| **Description of Duties:** | | | | | | |
| **Supervisor’s Name and Title:** | | | | **Starting wage:** | | **Ending wage:** |
| **May we contact for a reference?** | Yes No  □ □ | **Hours per week:** | |  | |  |
| **Reason for leaving:** | | | | | | |

**Employment History**

(continued)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Employer:** | | | **Address:** | | **Phone:** | |
| **From:**  **\_\_\_/\_\_\_\_** | **To:**  **\_\_\_/\_\_\_\_** | | **Job title:** | | | |
| **Description of Duties:** | | | | | | |
| **Supervisor’s Name and Title:** | | | | **Starting wage:** | | **Ending wage:** |
| **May we contact for a reference?** | Yes No  □ □ | **Hours per week:** | |  | |  |
| **Reason for leaving:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Employer:** | | | **Address:** | | **Phone:** | |
| **From:**  **\_\_\_/\_\_\_\_** | **To:**  **\_\_\_/\_\_\_\_** | | **Job title:** | | | |
| **Description of Duties:** | | | | | | |
| **Supervisor’s Name and Title:** | | | | **Starting wage:** | | **Ending wage:** |
| **May we contact for a reference?** | Yes No  □ □ | **Hours per week:** | |  | |  |
| **Reason for leaving:** | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Employer:** | | | **Address:** | | **Phone:** | |
| **From:**  **\_\_\_/\_\_\_\_** | **To:**  **\_\_\_/\_\_\_\_** | | **Job title:** | | | |
| **Description of Duties:** | | | | | | |
| **Supervisor’s Name and Title:** | | | | **Starting wage:** | | **Ending wage:** |
| **May we contact for a reference?** | Yes No  □ □ | **Hours per week:** | |  | |  |
| **Reason for leaving:** | | | | | | |

**Driving History**

**Please complete if you are 21 or older**

In the **past 3 years**, have you had any of the following major driving violations?

|  |  |  |
| --- | --- | --- |
| **DUI/DWI** | **Yes** | **No** |
| **Reckless Driving** | **Yes** | **No** |
| **Careless Driving** | **Yes** | **No** |
| **Vehicular Homicide** | **Yes** | **No** |
| **Leaving the scene of an accident** | **Yes** | **No** |
| **School Zone Violations** | **Yes** | **No** |
| **Financial Responsibility (no insurance)** | **Yes** | **No** |

In the **past 3 years** how many moving violations do you have? \_\_\_\_\_\_\_\_

In the **past 3 years** how many at-fault accidents have you had? \_\_\_\_\_\_\_\_

**Other Information**

|  |
| --- |
| **Describe specialized certifications, training, apprenticeships, skills, activities, and honors received:** |
| **State any additional information that may be helpful to us in considering your application:** |

**Military Experience**

|  |  |  |
| --- | --- | --- |
| **Branch of Service:** | **Dates Served:** | **Rank at Discharge:** |
| **Education and Training:** | | |

**References**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Address** | **Phone** | **Relationship** | **Alt. contact info** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |

# CONFLICT OF INTEREST DISCLOSURE

You are required to disclose if you have a conflict of interest. In order to determine if a conflict of interest does exist, the BHD needs you to check one or more of the boxes listed below if you have some interest in and to that entity **AND that entity is receiving payments from any of the Medicaid Waivers**. For the purposes of this paragraph an interest would include but is not limited to being an employee, independent contractor, officer, director/CEO, board member or having ownership of shares in a corporation, membership interest in a limited liability company, beneficiary interest in a statutory trust, ownership interest in a partnership or limited partnership or an interest of any kind or nature that could affect the operations of the entity such as voting shares/rights or managerial rights.

A conflict of interest may be determined by the BHD to exist if you check a box in which you may have some interest as set forth above in and to the entity that received payment from the Medicaid Waivers.

Please review the following list of entities and check any box in which you may have some interest as identified above.

Nonprofit corporation in W.S. 17-6-101 et seq.

Profit corporation in W.S. 17-16-101 et seq.

Limited Partnership in W.S. 17-14-101 et seq.

Limited Liability Companies in W.S. 17-15-101

Statutory Trust in W.S. 17-23-101

Sole proprietor interest in any company/business/entity

Interest of any nature in any other entity listed in Title 17

If any of the above boxes have been checked, on a separate piece of paper please give the full legal name of the entity, any name under which the entity may be doing business (include trade names registered with any state), physical address of the entity, mailing address of the entity, phone number and fax number if available and describe in detail your interest.

# Confidentiality and HIPAA Compliance Agreement

I acknowledge that during the course of performing my duties at Bridges Habilitation Services Inc. I may have access to, use, or disclose confidential information. I hereby agree to handle such information in a confidential and professional manner at all times during and after my employment and commit to the following obligations:

1. I will use and disclose confidential health information only in connection with and for the purpose of performing my assigned duties

2. I will request, obtain, or communicate confidential information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining, or communicating more confidential information than is necessary to perform my assigned duties

3. I will take responsible care to properly secure confidential information on my computer as applicable and will take steps to ensure that others cannot view or access such information. When I am away from my workstation or when my tasks are completed, I will log off my computer or use a password-protected screensaver in order to prevent access by unauthorized users.

4. I will not disclose my personal password(s) to anyone without the express written permission of my direct superior, or record or post it in an accessible location and will refrain from performing any task using another’s password

I understand that as an employee of a health care provider, the use and disclosure of patient information is governed by the rules and regulations established under HIPAA, the Health Insurance Portability and Accountably Act of 1996, and related policies and procedures of Bridges Habilitation Services Inc. Therefore with regard to client information I commit to the following obligation:

I will use and disclose confidential information solely in accordance with federal and organizational policies set forth above or elsewhere. I also agree to familiarize myself with any periodic updates or changes to such policies in a timely manner.

I acknowledge that as an employee of Bridges I have access to privileged and confidential information. I understand that Federal Law prohibits me from sharing this privileged information with any person or organization outside of Bridges. Furthermore, termination of employment does not put an end to my obligation to keep this information confidential.

I understand and agree to the following obligations:

1. I will not disclose: names of participants, health information, addresses, the content of any conversation with or about any participant or guardian, or any other information regarding participants, clients, or guardians who I encountered as a direct result of my employment at Bridges.
2. I will not share any information regarding Bridges methodology, training, documentation, operations, management, or personnel to any competing organization or individual.

The information about Bridges clients, personnel, operations, and management was given to me for the sole purpose of allowing me to perform my duties at Bridges. Therefore, any and all information acquired for that purpose is strictly confidential and cannot be used for any other purpose. This includes: memos, pay rates, management decisions, meeting notes or other internal communications.

I understand and agree that it is a legal and ethical violation to disclose information as described above. Furthermore, I understand that disclosing information to others may result in civil and/or criminal prosecution by the Federal Government, individual clients, guardians, or Bridges

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Signature Date

# Authorization and Acknowledgements

I certify that the facts contained in this application are true and complete to the best of my knowledge. I understand that if I am employed, any false statements on the application may be grounds for dismissal.

I authorize investigation of all statements contained in this application. I also grant permission to contact all references listed above, and authorize them to release all information concerning my previous employment and any other pertinent information these references might have, personal or otherwise. I release all parties from all liability for any damage that may result from furnishing this information to you.

I understand and agree that Bridges may obtain or have prepared a consumer/investigative consumer report concerning my prior employment, military record, education, character, general reputation, personal characteristics, criminal background or mode of living. By signing below, I authorize the company to obtain such a report(s).

I recognize that Bridges has the right to require an employment health assessment. I understand and agree that I may be asked to submit to drug, alcohol and other intoxicant screening before or after attainment of employment status.

I understand that, if employed, I am required to provide documents establishing my identity and eligibility to work in the United States. I understand and agree that, if hired, my employment is for no definite period and may be terminated at any time and without prior notice. I understand that nothing in this application constitutes an employment contract.

I understand that all Bridges’ facilities are non-smoking and I agree that I will not use tobacco products therein.

If employed, I will abide by the organization’s rules and procedures.

Applicant Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Rev. 1-14 har P: Forms/Applicant Forms/cm application*