Sunshine Community Care
Aim to Fulfill the Lives of the People we Serve

NH Office
9 Cedarwood Drive,unit 2
Bedford, NH 03110
Phone: 603-606-8762|Fax (603) 218 - 6108

Home Care Provider Questionnaire

Please Print All Information Requested

Date: _____

Personal Information

☐ Name: _____ Social Security_____

Last First Middle

Present Address: _____

Number Street City State Zip

Mailing Address (if different): _____

Have you lived outside of NH in the past 7 years? (Circle One) YES NO

If Yes: State: _____ Years: _____

State: _____ Years: _____

Have you ever been a homecare provider or foster care provider in the past? (Circle One) YES NO

Do you have a spare bedroom for the individual that you support to use? (Circle One) YES NO

Would you consider moving for a placement? (Circle One) YES NO

Gender: _____ Religion (if practiced in the home): _____

Email Address: _____

Primary Telephone: _____ Other Telephone: _____

How did you hear about Sunshine? _____

What languages other than English (if any) are used in the home? _____

Please list information for anyone living in your home *other than yourself* below:

Age	**Gender**

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59 Crawford Lane
Hooksett, NH 03106
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Please provide details on any pets living in the home:

Do you have a valid driver's license? YES NO State of Issue: _____License No. _____
(Proof Required)

Do you have automobile insurance? YES NO Carrier: _____
(Proof Required)

Do you have homeowners/renters insurance? YES NO Carrier: _____
(Proof Required)

Have you or anyone in your household ever been convicted of a felony or misdemeanor? YES NO

If yes, describe in full (use additional sheet of paper, if needed).

Have you or anyone in your household been convicted of a crime in the past ten years for substantiated rights violation including findings of abuse, neglect and/or exploitation, which has not been annulled, expunged, sealed by a court or overturned on appeal? YES NO

If yes, describe in full (use additional sheet of paper, if needed).

Education:

School	Name and Address of School	Dates:	Number of Years Completed	Did You Graduate?	Major & Degree
High School		From:			
		To:			
College/ University (BA, BS, AA)		From:			
		To:			

Bus. Or Trade School in addition to above		From:			
		To:			
Other (Specify)		From:			
		To:			

List qualifications you have that make you feel you will be a successful homecare provider? (Besides education and experience)

_____

_____

_____

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What interests you most about the field of human services? (Specifically working with individuals with disabilities)

Work Experience: Please list your work experience for the past five years beginning with your most recent job held.

Company Name	Telephone ( )
Address	Employed – (State month and year) From To
Name of Supervisor	Weekly pay Start Last
State job title and describe your work	Reason for leaving

May we contact the employer listed above? YES or NO

Work experience cont:

Company Name	Telephone ( )
Address	Employed – (State month and year) From To
Name of Supervisor	Weekly pay Start Last
State job title and describe your work	Reason for leaving

May we contact the employer listed above? YES or NO

Company Name	Telephone ( )
Address	Employed – (State month and year) From To
Name of Supervisor	Weekly pay Start Last
State job title and describe your work	Reason for leaving

May we contact the employer listed above? YES or NO

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Water Disclosure Form

Provider Name: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

I certify that the above residence uses: _____ City Water _____ Well Water. (Check one)

If my home uses well water, I will get water tested every 6 years and submit results to Sunshine Community Care. Should the water be not drinkable, I will get the water treated and retested. Alternate method for drinking water will be implemented should the water be deemed undrinkable.

_____ _____

Provider Signature Date

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EMERGENCY CONTACTS

Homecare Provider Name: _____ Date: _____

Local Emergency Contacts:

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Out of State Emergency Contacts (If applicable):

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Sunshine Community Care

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CONFIDENTALITY STATEMENT

The statement of confidentiality below is to be signed by those whom, during the course of their work or volunteer efforts within the environs of SUNSHINE COMMUNITY CARE, INC may come into contact with confidential information.

I understand and agree that in the performance of my duties as a contractor, I must strictly maintain the confidentiality of client information I may be exposed to during my association with Sunshine Community Care Inc.

I understand that Sunshine Community Care, Inc. operates under a strict confidentiality policy regarding individual care and that I may not disclose, publish or reveal to any person outside of the organization any information regarding individuals serviced. Confidential information includes, but is not limited to, personal or identifying information, appointment and content of records.

"(1) This does not prohibit disclosure to the State of New Hampshire or United States Government as required; (2) to an authorized representative of a client (such as a guardian), provided you have received the consent of Sunshine Community Care, Inc. or (3) as otherwise required by law."

Provider Signature Date

Sunshine Community Care Authorized Signature Date

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THE LEGAL RIGHTS OF DEVELOPMENTALLY IMPAIRED PERSONS IN NEW HAMPSHIRE

Below is a partial listing of the legal rights of developmentally impaired residents of the State of New Hampshire. If you have any questions concerning these rights, or feel that your rights have been in some way violated, call your Program Manager and let him know how you feel.

1. You have the same legal rights as everyone else in New Hampshire; you have the right to be treated with dignity and respect. This may include being called by the name that you like the most and having your wishes listened to and honored.

2. You have the right to be treated without discrimination, especially with regard to the severity of your disability.

3. You have the right to be free from abuse and neglect. This includes the right not to be shouted at, to have bad language used against you and to receive the services that you may need to protect you from harm.

4. You have the right to be informed; you have the right to know what is happening to you, and to have these rights explained to you.

5. You have the right to privacy. You have the right to limit access to your files. You have a right to confidentiality and to personal privacy. You have a right to be left alone.

6. You have a right to communicate openly and privately, by phone and letter, and to have access to visitors in your home in the community.

7. You have a right to make choices; to choose your clothes, personal possessions, medicine, the support services you want and the treatment you receive.

8. You have a right to be paid for the work that you do.

9. You have a right to access needed services and treatments. You have a right to quality treatment and services that use professional standards and modern knowledge.

10. You have a right to an Individualized Service Plan, to live in the least restrictive environment possible, which shall be voluntary on your part, and receive necessary medical care and treatment.

11. You have a right to know what to expect; all termination of services should be with 90 days' notice, and you have a right to challenge a termination. You have a right to complain, to know how to do so, your right to due process, and know whom you may complain to.

I have had these rights explained to me and I understand them.

Signature Date

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Sunshine Community Care

Independent Contractor HIPAA and Confidentiality

As an independent _____ contractor, I acknowledge and agree as follows:

I. I have read, understand and agree to abide by Sunshine's HIPAA policy.

2. I have completed, understand and agree to abide by the standards identified in Sunshine's. HIPAA training module.
3. I understand that unlawful disclosure of Client Protected Health Information (PHI) and electronic Protected Health Information (e-PHI) may result in termination of my contract.
4. If I witness or suspect that unlawful disclosure of PHI or e-PHI has occurred, I commit to immediately report said disclosure to my program's HIPAA liaison, Program Director and Executive Director or Sunshine's HIPAA Compliance Officer and I agree to participate in any resulting investigation to the best of my ability.

Independent Contractor Signature: _____

Date: _____

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Floor Plan

Indicate through drawing all routes out of the home as well as where household members will meet outside. Include locations of smoke detectors. Keep a copy of this form in your home.

Location: _____ Date:_____

Providers Name: _____

Evacuation Narrative: ***Include where members of the home will meet during an evacuation:***

_____
_____
_____
_____

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Household Census

Name of Household Member	DOB	Date of Criminal record check for all adults (18 or older) living in the home	Date of driving Record Check for all adults living in the home who will be driving the individual
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Number of Pets in the home:	

By signing this form, the volunteer provider confirms that this list includes all persons living in the home. Should another person move into the home I will inform Sunshine Community Care, INC. and obtain proper checks prior to their move-in. Also certifying that all persons in the home are not currently under any investigations by authorizes and have not been the subject of any client's rights investigations.

Provider Name: _____

Provider Address: _____

_____ _____

Providers Signature Date

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Reference Letter

Name of Candidate: _____

Name of Reference: _____

Relationship to Candidate: _____ Length of Relationship: _____

How would you describe this person? _____

_____

_____

_____

What are this person's strengths? _____

_____

_____

_____

What are this person's weaknesses? _____

_____

_____

_____

How does this person do in a high stress situation? _____

_____

_____

_____

Any additional comments: _____

_____

Signature: _____

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Authorization for Police to Release Record Information

Name: _____

DOB: _____ Phone: _____

Current Address: _____
Street City State Zip

Previous Address: _____
Street City State Zip

I _____ authorize the release of my criminal record as well as any other contact between myself and the Police Department (Including copies of arrest complaints pending final disposition in the courts, records of disturbances, records of suicide attempts or committals for involuntary hospitalization). I authorize the police department to release the above information to any associate of Sunshine Community Care.

Signature: _____ Date: _____