

**Home Provider Questionnaire**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone (H): \_\_\_\_\_

(W): \_\_\_\_\_

US Citizen? YES \_\_\_ NO \_\_\_

Have you been a home care provider or respite provider before? YES \_\_\_ NO \_\_\_

If yes, how was the experience, when and with what agency?

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

**CONVICTIONS:** Have you or anyone living in your household ever been convicted of a felony misdemeanor or founded with a substantial abuse against a client, adult or child:

YES \_\_\_ NO \_\_\_

If yes, please explain:

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

Do you have a driver's license? YES \_\_\_ NO \_\_\_

Do you have an automobile? YES \_\_\_ NO \_\_\_ Do you have liability insurance on your automobile? YES \_\_\_ NO \_\_\_

If yes, with whom are you insured and can you provide us with a copy of your insurance certificate?

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

Are any firearms kept in your home? YES \_\_\_ NO \_\_\_ If yes, where are they secured?

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

Please describe your method of storing prescribed and over-the-counter medication, which are present in your home.

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

Do you have any dependents live with you? YES \_\_\_ NO \_\_\_ If yes, please list all by name and age.

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

**Please list all adults 18 years and older living in your household:**

**(EACH PERSON LISTED NEEDS TO COMPLETE BACKGROUND CHECK PACKET)**

Name \_\_\_\_\_  
Relationship to applicant \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Name \_\_\_\_\_  
Relationship to applicant \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Name \_\_\_\_\_  
Relationship to applicant \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Name \_\_\_\_\_  
Relationship to applicant \_\_\_\_\_ Work Phone # \_\_\_\_\_

**Education                  Town                  State          Major/Degree                  Dates**

**High School**

\_\_\_\_\_

**College**

\_\_\_\_\_

**Graduate**

\_\_\_\_\_

**Other**

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**Personal References:**

Name \_\_\_\_\_ Address \_\_\_\_\_  
Home Phone# \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Relationship \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_  
Home Phone# \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Relationship \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_  
Home Phone# \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Relationship \_\_\_\_\_

**Employment History and Reference (list most recent first)**

Employer \_\_\_\_\_ Supervisor \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
May we contact him/her as a reference? YES \_\_\_ NO \_\_\_

Employer \_\_\_\_\_ Supervisor \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
May we contact him/her as a reference? YES \_\_\_ NO \_\_\_

Employer \_\_\_\_\_ Supervisor \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
May we contact him/her as a reference? YES \_\_\_ NO \_\_\_

Providing services to individuals with disabilities may involve physical and emotional demands. Please indicate any limitations or concerns you may have in this area.

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Do you believe you are connected to your community and in what ways are you connected? \_\_\_\_\_

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What type of person do you wish to work with?

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Would you prefer to work with a male or female? \_\_\_\_\_  
Why?

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How do you spend your free time?

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Do you have any hobbies or special interests?

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Can an individual who is placed with you participate with you in your activities?

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Do you have any pets? YES \_\_\_ NO \_\_\_  
If yes, what kind and how many?

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**Physical Setting:**

Type of housing: Own House \_\_\_ Rent House \_\_\_ Rent Apartment \_\_\_  
# of Rooms \_\_\_ # of bedrooms \_\_\_ # of bathrooms \_\_\_

Where are bedrooms located? \_\_\_\_\_

Where are bathrooms located? \_\_\_\_\_

Tub/Shower? \_\_\_\_\_

Water Supply: Public \_\_\_ Well \_\_\_

Sewer System: Public \_\_\_ Private \_\_\_

Physical Accessibility:

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Description of property:

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Proximity of nearest neighbor:

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How would you best describe the geographic area you live in?

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Do you have homeowners insurance? YES \_\_\_ NO \_\_\_ If yes, with whom are you insured and can you provide us with a copy of your insurance certificate?

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Please write a brief statement. What is your philosophy of working with individuals with developmental disabilities? What are your views and beliefs?

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In submitting this questionnaire, I understand that: Any offer of contracted services is conditional upon receipt of satisfactory references, motor vehicle records check and criminal records check. Any material, misrepresentation or omission of fact in this questionnaire may result in rejection of any offer or termination of contract. In connection with my questionnaire, I authorize PathWays of the River Valley and any agent acting on its behalf, to conduct an inquiry as to my record of any and all of my former and present employers, references, any or all educational institutions, for all members of my household as to any felony and misdemeanor convictions or history of adult, child/client abuse. I hereby release and discharge PathWays of the River Valley and all others from any liability for damages, which may result from such investigations. All responses are correct to the best of my knowledge. I understand that this form is not a contract or an offer to perform contracted services. I further understand that I would be an Independent Contractor and not an employee of PathWays of the River Valley.

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