

EMPLOYMENT FORM

Section 1: Worker's Information (Worker to Complete)

Worker's First Name:	MI:	Last Name:
Home Phone Number:		Cell Phone Number:
Email Address: (required)		
Mailing Address (PO Box):		Apartment #:
City:		State:
Zip Code:		County:
Emergency Contact:		Home Phone Number:
Relationship:		Cell Phone Number:

Section 2: Employer's Information (Participant/Designee to Complete)

Employer (Participant) First and Last Name:	
Designated Representative/Designee (If applicable):	Is individual receiving services 18 years or older: YES NO
Home Phone Number:	Cell Phone Number:
Email Address:	
Will the worker be a back-up Support Worker? YES NO Back-up workers must remain up to date with annual training requirements and adhere to the Back-up Workers Guidelines.	Will the worker provide transportation or run errands? YES NO
Support Worker's Schedule: (choose one)	
<input type="checkbox"/> Set Schedule: Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday _____	<input type="checkbox"/> Variable Hours / No Set Schedule. * *Please be advised, a six-month look back measurement period will determine benefits eligibility. *Vacation PTO nor NYS Paid Sick Leave <u>will not</u> be paid out upon separation from employment.

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Section 3: Attestation Statements (Worker to Complete, Participant/Designee to sign)

Worker's Full Name:	
Have you ever been convicted of a motor vehicle moving violation, including, but not limited to, alcohol and drug-related offenses?	
<div style="display: flex; justify-content: space-between;">_____ YES_____ NO</div>	
If yes, please describe. You must indicate any suspension, revocation, or occurrence involving harm to human beings or property while driving.	
Are you currently working with another participant in Self-Direction?	
<div style="display: flex; justify-content: space-between;">_____ YES_____ NO</div>	
Under the Self-Direction Program, the following relationships to the Participant cannot be hired as staff:	
<ul style="list-style-type: none">• Parents,• Legal Guardians,• Spouses,• Adult Children,• Son-in-laws and Daughter-in-laws; and/or• Any family member/relative that resides in the Participant's home.	
I certify that I am 18 years or older as required by OPWDD to be hired in the Self-Direction program _____ (initial or check here)	
<u>Choose one:</u>	
I certify that I am not related to the Participant for whom I will be working in any of the relationships listed above _____ (initial or check here)	
OR	
I certify that if I am a family member/relative not listed above, I do not reside in the Participant's home _____ (initial or check here)	
By signing the below, I certify that the information provided in this document is true, accurate and complete, and I certify knowing that any falsification, misrepresentation or omission of this information may cause the withdrawal of any conditional offer or termination of employment, if hired, by my Employer (Participant), regardless of the timing or circumstances of discovery.	
_____ Worker Signature	_____ Date
_____ Employer/Participant/Designee Signature	_____ Date