CARE Hawaii, Inc.

875 Waimanu St.
Honolulu, HI 96813
Telephone: (808) 533-3936

Application for Employees and Fee-for-Service Providers

Due to the State of Hawaii standards we are unable to accept faxed or copied applications.

To be considered for a position, whether as an employee or a fee-for-service- provider within our company, you must complete **all portions** of this application. If you fail to submit the additional required supporting documents with your application we will not process your application. In addition to completing this application you must submit a **DATED resume or curriculum vitae**. It must be specific regarding the time spent at each position.
****GAPS in employment must be explained in writing.**

Please let us know if you need assistance in the completion of this application. If more space is needed than provided on this original, please attach additional sheets and reference the questions being asked. If a question is not applicable to you please mark **N/A** in the space. Your application and accompanying material are confidential and becomes our property. **You must notify this office in writing of any changes to your name, address, telephone number, or availability.**

Please type or print legibly in ink.

Name: ____
(Last) (First) (Middle Initial)

All other names used (for purposes of checking past work record/history):

____

Home Address: ____

____

Mailing Address: ____

____

E-mail: ______________________ Cellular phone: ______________________

Home phone: ______________________ Alternate phone: ______________________

Fax: ______________________ Pager: ______________________

Social Security Number: ____________________

Are you legally authorized to work in the U.S.? (circle) Yes No

[Note: If offered employment, you will be required to submit the Immigration & Naturalization Form I-9 as required by the 1986 Immigration Reform and Control Act.]

Position for which you are applying for: ____

How were you referred to the company? ____

Do you have friends or relatives working for the Company? ____________________________________

Education/Training

<u>IMPORTANT</u>:

To comply with State of Hawaii standards, you are required to submit <u>original transcripts</u> of all college work. All <u>official transcripts must be sent directly from your school to CARE Hawaii, Inc.</u> We need to review all courses completed. You must also provide, on a separate sheet of paper, a chronological listing of all previous experiences including education and training experience including but not limited to private practice and teaching. Also, please provide a narration of any breaks in experience.

A. Name and location of last grade school attended: (elementary, intermediate, high school)					**Highest grade level completed:**
B. In-Service Training, Business, Trade, College, Graduate, or Professional Schools					
Name of School and Address (include Street, City, State, Zip Code, Telephone #)	**Course of Major, Field of Study, or Type of training**	**Number of years attended**	**Did you graduate and/or receive a degree, diploma or certificate?**	**Kind of Diploma or Certificate Received**	**Date Transcript Requested for CARE Hawaii**

Practicum:

____
Hospital/Agency

____
Mailing Address City State Zip

____
Specialty Date of Completion (month/year)

____
Dates of internship (From – To) Telephone Number

- Did you successfully complete the program? ☐Yes ☐ No (If no, give a brief narration)
- If you participated or were a part of any other practicum please note on a separate sheet of paper and attach.

Internship:

____
Hospital

____
Mailing Address City State Zip

____
Specialty Date of Completion (month/year)

____
Dates of internship (From – To) Telephone Number

- Did you successfully complete the program? ☐Yes ☐ No (If no, give a brief narration)
- If you participated or were a part of any other internship please note on a separate sheet of paper and attach.

Professional Medical School Information (*For applicants who are medical doctors*):

____
School Attended

____
Mailing Address City State Zip

____
Degree Received Date of Graduation (month/year)

____
Dates of attendance (From – To) Telephone Number

Foreign Medical Graduates: Attach a photocopy of your ECFMG Certificate

Residencies:

1) ____
Institution

____
Mailing Address City State Zip

____
Specialty Date of Completion (month/year)

____
Dates of residency (From – To) Telephone Number

- Did you successfully complete the program? Yes No (If no, give a brief narration)

2) ____
Institution

____
Mailing Address City State Zip

____
Specialty Date of Completion (month/year)

____
Dates of residency (From – To) Telephone Number

- Did you successfully complete the program? Yes No (If no, give a brief narration)
- If you participated or were a part of any other residencies please note on a separate sheet of paper.

Fellowship:

____
Institution

____
Mailing Address City State Zip

____
Specialty Date of Completion (month/year)

____
Dates of fellowship (From – To) Telephone Number

- Did you successfully complete the fellowship program? Yes No (If no, give a brief narration)
- If you participated or were a part of any other fellowships please note on a separate sheet of paper.

Specialty and Board Certification:

Please list those specialty American Boards by where you were/are certified if any:

1) American Board of:____

Specialty: ____________________ Sub-Specialty:________________

Certificate #:__________________ Expiration Date, if any: ____________

Recertification date, if any: ___________________________________

2) American Board of:____

Specialty: ____________________ Sub-Specialty:________________

Certificate #:__________________ Expiration Date, if any: ____________

Recertification date, if any: ___________________________________

If you are certified with a board other than the American Board or if you are certified with more than two specialty boards, please note on a separate sheet of paper and attach.

____

____

Affiliations/Experience:

List all present and previous hospital, agency, and clinical affiliations in chronological order:

____
1) Name of Organization Dates (From – To)

____
Mailing Address City State Zip Code

____
2) Name of Organization Dates (From – To)

____
Mailing Address City State Zip Code

____
3) Name of Organization Dates (From – To)

Mailing Address City State Zip Code

4) Name of Organization Dates (From – To)

Mailing Address City State Zip Code

- If you were affiliated with more than four health care organizations, please list them on a separate sheet of paper with the mailing address and the dates you were affiliated.

Licensures:

To comply with State of Hawaii standards, you are required to submit a clear photocopy of all current professional license(s). Please submit a copy of LICENSE CERTIFICATE showing date you were duly licensed and your CURRENT IDENTIFICATION CARD for verification.

State in which Professional License was issued	Issuing Licensing Authority	License Number	Dated Issued (Month/day/year)	Expiration Date

Have you fulfilled CME requirements as required for State licensure? ☐Yes ☐ No

Please attach clear photocopies of your current certification of Federal Controlled Substance Registration Certificate (DEA) and the State of Hawaii's Certificate of Registration for Controlled Substances (CDS). If there are any restrictions on either of these certificates, please list them. On a separate sheet of paper and attach.

Federal DEA Registration No.: ____________ Expiration Date: __________ Any Restrictions?:___________

State CDS Registration No.: ____________ Expiration Date: __________ Any Restrictions?:_____________

Other Certification(s): (Please indicate the kind, registration number, and the State or other licensing authority.):

Type of Certification	Issuing Authority	Certification Number (if any)	Dated Issued (Month/day/year)	Expiration Date

Special skills: (List any special skills or training)

A. **Have you attended any Felix Staff/Service Development Institute (FSSDI) Trainings, which are required for providers who want to provide assessment and Therapeutic Aide services? Yes*____ No _____**

***IMPORTANT: If you have attended any FSSDI trainings please submit a copy of FSSDI CERTIFICATE showing date you were certified.**

C. **Knowledge of Language Other Than English**

Language	Speak	Read	Write

D. **Are you CPR certified? Yes ________ No ________ (*If yes, please submit your CPR certification card with your application.)***

E. **Are you certified in First Aid? Yes ________ No ________ (*If yes, please submit your First Aid certification card with your application.)***

F. **Do you have a current driver's license? Yes ______ Type (e.g. 3): _______ NO (not #) ______ *(If yes, it is required that you submit copy of current driver's license)***

G. **Do you have access to a vehicle that is covered by auto insurance? Yes ______ No ______ *(If yes, it is required that you submit current auto documents (including auto insurance, safety check & registration.)***

H. **Please submit documentation of your TB clearance.**

Employment History

Include all previous work experience: Full-time, part-time, and volunteer experience. Begin with your present or last job held. Describe in detail nature of work personally performed by you. Also, give dates and explain unemployed periods. Attach additional sheet if you need more space.

To comply with State of Hawaii standards we are required to send out Confidential Reference Inquiry Forms to each employer listed. Complete addresses are needed in this section.)

Employer:	Dates of Service To: From:
Address:	Average hours per week:
Telephone Number(s):	Starting hourly rate or monthly salary:
Name and title of your Supervisor:	Final hourly rate or monthly salary:
Your Title:	
Job duties:	
Reason for leaving:	

Employer:	Dates of Service To: From:
Address:	Average hours per week:
Telephone Number(s):	Starting hourly rate or monthly salary:
Name and title of your Supervisor:	Final hourly rate or monthly salary:
Your Title:	
Job duties:	
Reason for leaving:	

Employer:	Dates of Service To: From:
Address:	Average hours per week:
Telephone Number(s):	Starting hourly rate or monthly salary:
Name and title of your Supervisor:	Final hourly rate or monthly salary:
Your Title:	
Job duties:	
Reason for leaving:	

Employer:	Dates of Service To: From:
Address:	Average hours per week:
Telephone Number(s):	Starting hourly rate or monthly salary:
Name and title of your Supervisor:	Final hourly rate or monthly salary:
Your Title:	
Job duties:	
Reason for leaving:	

Employer:	Dates of Service To: From:
Address:	Average hours per week:
Telephone Number(s):	Starting hourly rate or monthly salary:
Name and title of your Supervisor:	Final hourly rate or monthly salary:
Your Title:	
Job duties:	
Reason for leaving:	

Professional and/or Personal References

As part of our screening process, we may send out Professional and/or Personal Reference Inquiry Forms. Complete addresses are needed in this section. Please provide three references, preferably from your specialty area (not including relatives, current partners, or associates in practice). References should be professionals who have significant personal experience and can attest to your job capabilities, ethical character, and ability to work with others.

1. Reference Name:______________________________________ Title:__________________________________

   Mailing Address: ____
   Street City State Zip Code

   Telephone Number(s): ____

   How does this person know of your professional abilities? ____

2. Reference Name:______________________________________ Title:__________________________________

   Mailing Address: ____
   Street City State Zip Code

   Telephone Number(s): ____

   How does this person know of your professional abilities? ____

3. Reference Name:______________________________________ Title:__________________________________

   Mailing Address: ____
   Street City State Zip Code

   Telephone Number(s): ____

   How does this person know of your professional abilities? ____

Provider Directory

Our agency publishes Provider Directories at periodic intervals, which list your personal address, telephone and other information that you have provided. This directory may be used by our administration, other providers, care coordinators, etc. who may need to reach you. Please specify any information that you **DO NOT WISH** to have published:

____

____

Billing Information

Primary office address: ____

Office telephone: __________________________ Office fax number: ___________________________________

Office contact person: ______________________ Office Days & hours: _________________________________

Do you have 7 day/week, 24-hour/day back-up and or on–call coverage? (circle) Yes No

Tax ID Name (To appear on check):____

Address to send check (If other than mailing address): ____

General Excise Tax License Number (Please submit a copy for verification): _______________________________

Professional Liability Coverage Information:

Please list the names and complete address of ALL current and past liability coverage carriers covering the entire period of your professional career. Attach additional sheets if necessary. Please include a photocopy of your current professional liability coverage, declaration page only.

1. Company Policy #

Mailing Address City State Zip

Coverage amount: Per claim Per aggregate Effective date Expiration Date

Please list any and all exclusions or limitations

2. Company Policy #

Mailing Address City State Zip

Coverage amount: Per claim Per aggregate Effective date Expiration Date

Please list any and all exclusions or limitations

3. Company Policy #

Mailing Address City State Zip

Coverage amount: Per claim Per aggregate Effective date Expiration Date

Please list any and all exclusions or limitations

Provider Organization Information:

Please indicate all provider organizations of which you are a member and your corresponding provider numbers:

Name: ____ SS#: ________________________
(Last Name) (First Name) (MI)

Aloha Care #: ____________________________

Champus/Tricare #: _______________________

HMAA Provider #: _______________________

HMSA Provider #: ________________________

HMSA-QUEST#: _________________________

Medicaid #: ______________________________

MEDICARE #: ___________________________

UHA #: _________________________________

VA #: ___________________________________

Other #: ________________________________

Other #: ________________________________

CARE Hawaii, Inc.
875 Waimanu St.
Honolulu, Hawaii 96813
Telephone: (808) 533-3936

AUTHORIZATION FOR RELEASE OF INFORMATION

All applicants must complete and sign this form as part of your application.

I, ______________________________________, hereby authorize representatives of **CARE Hawaii, Inc.**, **Child and Adolescent Mental Health Division** (hereafter referred to as CAMHD) and **Department of Education** (hereafter referred to as DOE) to consult with representatives of other hospitals, institutions, government agencies, previous employers, and other persons or entities (hereafter collectively referred to as "persons" or "entities") to obtain and verify information concerning my professional qualifications, competence, moral character, ethical qualifications, and physical and mental condition and to conduct criminal background checks and Child Abuse and Neglect checks.

I consent to release by any and all hospitals, institutions, government agencies, previous employers, and other persons or entities to **CARE Hawaii, Inc.**, **CAMHD** and **DOE** all information and documents that may be relevant to an evaluation of my professional qualifications, competence, moral character, ethical qualifications and physical and mental condition.

I hereby release all representatives of **CARE Hawaii, Inc.**, **CAMHD**, **DOE** and all such persons or entities from any and all liability for their acts performed in good faith and without malice in giving, obtaining, and verifying such information in connection with evaluating my applications, my credentials, and my qualifications.

I understand and agree that I, as an applicant, have the burden of producing adequate information to demonstrate to the satisfaction of **CARE Hawaii, Inc.** and/or **CAMHD**, and/or **DOE** my professional qualifications, clinical competence, moral character, ethical qualifications and physical and mental condition and for resolving doubts thereto. I further understand and agree that it is my responsibility to inform **CARE Hawaii, Inc.** of any changes in the information provided through the application during the application period or at any subsequent time.

Signature of Applicant: ____ Date: _________________

Printed Name of Applicant: ____

CARE Hawaii, Inc.
875 Waimanu St.
Honolulu, Hawaii 96813
Telephone: (808) 533-3936

AFFIRMATION:

I represent that information provided in or attached to this credentialing/employment application form is accurate. I understand that any false or misleading statements or omission regarding this application, whether intentional or not, whenever discovered are grounds for and is cause for automatic and immediate rejection of this application and may result in the denial of appointment and clinical privileges. Upon subsequent discovery of such misrepresentation, misstatement, or omission, **CARE Hawaii, Inc.** may immediately terminate my appointment.

Signature of Applicant: ____ Date: ________________

Printed Name of Applicant: ____

RELEASE AND IMMUNITY:

I understand and agree that by applying for a position with **CARE Hawaii, Inc.**, regardless of whether I obtain the position:

1. I authorize the release of all information necessary for an evaluation of my qualifications for initial appointment and or privileges;
2. I authorize **CARE Hawaii, Inc.**, it's staff and their representatives to consult with any prior associate and others who may have information bearing on my professional competence, character, qualifications, including ethical, and ability to work well with others;
3. I agree to release from liability **CARE Hawaii, Inc.**, its staff, or anyone acting by and/or for it, who act without malice for any matter relating to this application for inclusion and referral, the evaluation of my qualifications or any matter related to appointment or clinical privileges; and
4. I release from liability **CARE Hawaii, Inc.** and its staff for all matters relating to appointment and clinical privileges or qualifications for the same, if such acts are made without malice.

Signature of Applicant: ____ Date: ________________

Printed Name of Applicant: ____

CARE Hawaii, Inc.
875 Waimanu St.
Honolulu, Hawaii 96813
Telephone: (808) 533-3936

Disciplinary/Corrective Action Form

All applicants must complete and sign this form as part of your (fee-for-service or employment) application.

Name____ SSN# ____________________
(Last) (First) (Middle Initial)

The information requested below is needed to determine your suitability for employment. Convictions, dismissals from employment or less than honorable discharges from military service will not necessarily bar employment or a fee-for-service relationship with CARE Hawaii, Inc. Factors such as date of the offense, seriousness, and nature of the violation and rehabilitation will be taken into consideration.

1. **Have any of the following actions ever been taken, or are in the process of being taken, which resulted or may result in: revocation, censure, written reprimand, restriction, non-renewal or denial of right or privilege, suspension, fine, reduction, limitation, placed on probation, required performance of public service, a course of education training, counseling or monitoring, resignation, leave of absence, withdrawal of an application, termination or non-renewal of a contract, or voluntary[1]/involuntary relinquishment or voluntary[1]/involuntary non-renewal?**

YES	NO	
Θ	Θ	License in any state
Θ	Θ	Other professional registration/license/certification
Θ	Θ	State/Federal DEA registration, if applicable
Θ	Θ	Academic appointment
Θ	Θ	Membership or loss or limitation of clinical privileges at any hospital staff
Θ	Θ	Other institutional affiliation
Θ	Θ	Professional society/membership
Θ	Θ	Participation in any third party payor program
Θ	Θ	Other institutional affiliation or status
Θ	Θ	Board certification
Θ	Θ	Any other disciplinary actions

A. Has your license to practice your profession in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have been fined or received a letter of reprimand – or is such action pending?

____ Yes _________________ ____ No _____ Not Applicable
(Month/year)
If Yes, please explain:

____

____

____

B. Have you ever voluntarily relinquished privileges or a license anywhere at any time?
Voluntary relinquishment or voluntary non-renewal is a disciplinary action when the relinquishment is done to avoid an adverse action, preclude an investigation, or is done while the licensee is under investigation related to professional conduct.

____ Yes __________________ ____ No _____ Not Applicable
(Month/year)
If Yes, please explain:

____

____

____

2. Dismissals

A. Have you been fired or asked to resign from employment?

____ Yes __________________ ____ No
(Month/year)
If Yes, please explain:

____

____

____

B. Has your contract with any medical organization (i.e. hospital, health plan, health maintenance organization (HMO), professional association, medical school, or other health delivery entity or system) ever been suspended, terminated, or not renewed ---or is such action pending?

____ Yes __________________ ____ No _____ Not Applicable
(Month/year)
If Yes, please explain:

____

____

____

3. Qualification standards

A. TB Clearance
Are you able to submit documentation of your TB clearance with this application? This is a legal requirement. _____ Yes _____ No

If No, please explain:

____

____

____

B. Reasonable Accommodation
Are you able to perform the procedures and essential functions of the position for which you have applied with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to clients?

_____ Yes _____ No

If No, please explain:

____

____

____

C. Criminal Convictions
Have you ever been convicted of a crime, pled guilty or "no contest" to a crime (within the past 10 years)?
Include ALL felony and misdemeanor convictions for traffic and/or criminal cases

_____ Yes _____ No

If Yes, please explain:

____

____

____

D. Illegal Drug
Do you presently or have you used any illegal drugs in the past two years?

_____ Yes _____ No

If Yes, please explain:

____

____

____

4. Malpractice Information

A. Have there been, or are there pending, any suits, malpractice claims, settlements or arbitration proceedings involving your professional practice?

____ Yes _________________ ____ No _____ Not Applicable
(Month/year)

If Yes, please explain:

____

____

____

B. Have you been denied professional liability insurance or has your coverage ever been cancelled?

____ Yes _________________ ____ No _____ Not Applicable
(Month/year)
If Yes, please explain:

____

____

____

Please sign and date to acknowledge that all the information (Questions 1 – 4) that you have provided are true to the best of your knowledge.

____ _________________________________
Signature Date

Employment/Fee-for-Service Application Agreement

Please Read Carefully Before Signing:

1. I certify that all statements made on or in connection with this application including those regarding my education, training, and certification employment record and certification are true and correct to the best of my knowledge. I agree and understand that any material misstatements or omissions from this application constitute cause for denial of my application and/or termination of for participation with CARE HAWAII, INC. programs.

2. I hereby signify my willingness to appear for interviews in regard to my application if deemed necessary.

3. I acknowledge that I, as an applicant for participation in the Company (CARE Hawaii, Inc.), have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualification.

4. As an equal opportunity employer, this Company's policy in accordance with Federal and State Law, prohibits discrimination in employment or practices on the basis of based on race, color religion, sex, national origin, disability, age, marital status, military service, veteran status or any other characteristic protected by law.

5. If employed by or offered a contract for a position to participate as a fee-for-service provider with the Company (CARE Hawaii, Inc.), I agree to conform to the Bylaws, policies and procedures of the Company. I understand that if employed, my employment is at will and can be terminated at any time and for any reason with or without advance notice.

6. **I understand and agree that nothing in this credentials form/application is intended to imply or create an employment contract or a fee-for-service contract, or obligation or promise by the Company.**

7. **I understand and agree that only the Chief Executive Officer in conjunction with the approval of the Human Resources Manager of CARE Hawaii has any authority to enter into any agreement to employ me or contract my services for any specified period of time or to modify the at-will nature of my employment or terms and conditions of service contract. I acknowledge that any modifications to the terms and conditions of my employment or service contract must be in writing and signed by the Chief Executive Officer and I will not rely on anything else.**

8. I understand and agree that if offered employment or a fee-for-service contract by the Company (CARE Hawaii, Inc.), I will disclose criminal conviction information in accordance with the law, and that such employment or contract offer shall be dependent upon the receipt of a satisfactory conviction record as determined by the Company. The company may withdraw a conditional employment offer if you have a criminal conviction record which bears a rational relationship to the duties and responsibilities of the position which you are applying.

9. I understand and agree that if offered employment on a fee-for-service contract by the Company (CARE Hawaii, Inc.), I will disclose military service information in accordance with the law, and that such employment or fee-for-service contract offer shall be dependent upon the receipt of satisfactory military record.

10. I verify that I am appropriately qualified to perform all the procedures I currently perform in the practice of my profession.

11. I pledge to provide continuous care to my patients, and to refrain from delegating responsibility or care of my patients to any person not qualified to undertake that responsibility.

12. **I understand that this application is an ongoing process and I must notify CARE Hawaii offices of any changes to information provided.**

13. Arbitration Agreement: In consideration for the Company's (CARE Hawaii, Inc.) examination and investigation of my application and in order to promptly resolve any legal dispute I may have with the Company regarding my recruitment, hiring, employment or termination of employment or fee for services relationship and contract, I agree to submit any and all such claims to final and binding arbitration pursuant to the Federal Arbitration Act, 9 U.S.C. § 1 et seq. and the Hawaii Arbitration Act in Honolulu, Hawaii.

______________________________	______________
Signature of applicant	**Date**

14. **I understand that all information submitted and obtained as a part of the application and credentialing process (verification of education, work experience, licensure, certifications, etc.) may be submitted for review /approval by the Department of Health and/or Department of Justice.**

15. A photo static copy of this original statement constitutes my written authorization and request to release any and all documents relevant to this application. Said photo static copy shall have all the same force and effect as the signed original.

______________________________	______________________________	______________
Signature of Applicant	**Print Name of Applicant**	**Date**

CARE Hawaii Incorporated will treat this provider credentials application and any information secured in connection herewith in strict confidence and will employ all reasonable safeguards to protect the Applicant's privacy.

VOLUNTARY DISCLOSURE FORM

THIS INFORMATION IS ASKED FOR RECORD KEEPING PURPOSES ONLY AND WILL NOT BE KEPT AS PART OF YOUR APPLICATION

Name: ____
Last First MI

Application Date: ______________________________

Position Applied For: ______________________________

Race:
- ☐ White
- ☐ Hispanic
- ☐ African American
- ☐ Asian/Pacific Islander
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Hawaiian or Part-Hawaiian
  - ☐ Japanese
  - ☐ Korean
  - ☐ Samoan
  - ☐ Vietnamese
  - ☐ Other: ______________

Sex: ☐ Male ☐ Female

Referred by:
- ☐ Agency Name ______________________________
- ☐ College Recruitment (Name) ______________________________
- ☐ Employee Referral (Name) ______________________________
- ☐ Employment Office (Name) ______________________________
- ☐ Internal Posting ______________________________
- ☐ Internet/E-Recruitment ______________________________
- ☐ Newspaper Ad (Name) ______________________________
- ☐ Unsolicited Resume ______________________________
- ☐ Walk-In ______________________________
- ☐ Other: ______________________________