

# LIFESHARING PROVIDER APPLICATION



**FOR MORE INFORMATION:**

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Date of application: \_\_\_\_\_



## LIFESHARING APPLICATION

*Applicants are considered without regard to race, color, religion, sex, national origin, age, marital or veteran status or presence of a non-job related medical condition or disability.*

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### **Primary Lifeshare Provider:**

Name: \_\_\_\_\_ Email: \_\_\_\_\_

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

School District: \_\_\_\_\_

Township: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Have you been a resident of PA for at least 2 years? \_\_\_\_\_ Have you ever filed for bankruptcy? \_\_\_\_\_  
(If not, FBI clearances must be completed)

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### **Alternate Lifeshare Provider:** (Maybe spouse, household/family member or neighbor)

Name: \_\_\_\_\_ Email: \_\_\_\_\_

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

School District: \_\_\_\_\_

Township: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Have you been a resident of PA for at least 2 years? \_\_\_\_\_ Have you ever filed for bankruptcy? \_\_\_\_\_  
(If not, FBI clearances must be completed)

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### **Children/Other Adults Living in the Home:**

First and Last Name	Date of Birth	Relationship	Social Security Number

**Personal Information:**

	Primary Lifeshare Provider	Alternate Lifeshare Provider
Date of birth		
Social Security Number		
U.S. Citizen		
Marital Status		
Date of Marriage		

**Education:**

	Primary Lifeshare Provider	Alternate Lifeshare Provider
Highest Grade Completed		
College Degree		
Other Training/Certificates		

**Work Experience: Primary Lifeshare Provider**

Apart from the recent jobs listed below, have you ever worked in human services including child/adult care? (Circle) **YES** **NO**

Employer: \_\_\_\_\_ Position title: \_\_\_\_\_

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

Job Description: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Dates of employment: From \_\_\_\_\_ To \_\_\_\_\_ Employer phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Position title: \_\_\_\_\_

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

Job Description: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Dates of employment: From \_\_\_\_\_ To \_\_\_\_\_ Employer phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Position title: \_\_\_\_\_

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

Job Description: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Dates of employment: From \_\_\_\_\_ To \_\_\_\_\_ Employer phone: \_\_\_\_\_

**Volunteer/Related Training Experience:**

Please list any other schooling, volunteer work, training or certification which relates to the Lifeshare Provider role including experience in Mental Health, Intellectual Disability, Medical Care, Child Care, Physical Disabilities, or other Human Service Occupations.

Primary Lifeshare Provider	Alternate Lifeshare Provider

**Health:**

Please complete questions to the best of your ability.

	Primary Lifeshare Provider	Alternate Lifeshare Provider
How would you describe your general physical health?		
Do you have a chronic health problem? If yes, please describe.		
Are you free from contagious disease?		
Have you been vaccinated for Hepatitis B?		
Mental Health Services received (including counseling and inpatient services with dates)		
Do you provide healthcare for a family or household member?		

**Description of Home and Neighborhood:**

Type of home you reside in: Single Twin Townhouse Apartment Row Home Other \_\_\_\_\_

Please check best answer: Owner Buying Renting If renting, lease expiration \_\_\_\_\_ Total # of rooms: \_\_\_\_\_

How long have you resided at current residence? \_\_\_\_\_ Do you have Homeowners or Renters Insurance? \_\_\_\_\_

Any current lien (s) on your home? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Please describe your yard or available outdoor property: \_\_\_\_\_

How do you think your neighbors would react with a person with disabilities living in your home? \_\_\_\_\_

Do you have pets? \_\_\_\_\_ What kind? \_\_\_\_\_ How many? \_\_\_\_\_

**Planned occupancy:**

Please indicate the names and other information of people who you reside with you or those you expect to move in or out of the home, e.g. aging parent, student returning from school, family member returning from active duty.

Name (First & Last)	Age	Move in/Move Out	Expected Move Date	Needs in Home Care (Yes or No)

Is there an available, currently unoccupied bedroom for the individual living with you? \_\_\_\_\_

Type of heating: \_\_\_\_\_ If Oil, when was the last time the heater was inspected? \_\_\_\_\_

Do you use a fireplace or wood burning stove? \_\_\_\_\_ Date chimney was last cleaned? \_\_\_\_\_

**Transportation:**

Make, model and year of your automobile \_\_\_\_\_

Do you have current car insurance? **Yes** **No** Date of expiration \_\_\_\_\_

Are you willing to transport an individual to necessary appointments? \_\_\_\_\_

Is public transportation available in the area? **Yes** **No** If yes, what type and how close? \_\_\_\_\_

Describe the volume of traffic on your road: \_\_\_\_\_

Are there sidewalks for pedestrians? **Yes** **No** Are there any parks or recreation areas nearby? **Yes** **No**

**Care and Support:**

What is the name of the closest hospital to your home? \_\_\_\_\_ How far? \_\_\_\_\_

Do you have a support network who would be willing to provide backup care for an individual with disabilities?

Why would you like to become a Lifeshare Provider?

What are the benefits of working with the natural family?

Are you now, or have you ever provided foster care in your home? **Yes** **No** If yes, please complete information.

Are you now, or have you every provided LifeSharing Services in your home? **Yes** **No** If yes, please complete below

Dates of service	Name of agency	# of individuals, adults and/or children	General diagnoses

**References/Criminal Clearances:**

Are you willing to allow Person Directed Supports to get a letter of reference from the above names agencies? **Yes** **No**

Please give the following information for 3 non-related personal references. A letter will be sent asking them to respond to some questions.

Name	Address	Phone number	Relationship & years known

Please give the following information for 1 work related professional reference. A letter will be sent asking them to respond to some questions.

Name	Address	Phone number	Relationship & years known

Below, please answer **yes** or **no** for each adult in the home. If yes, please give date and location by county/state and any related information including a copy of the docket sheet of each offense, which must also be provided. Conviction of criminal offenses will not necessarily prohibit the ability to become a provider. Each case is considered on its own merit.

	Primary Lifeshare Provider	Alternate Lifeshare Provider	Other Adult in home
Convicted of a criminal offense, including Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) (for either alcohol or drugs) in PA or other state?			
Psychiatrically hospitalized?			
Treated for Substance Abuse or addiction in the last ten years?			
Involved with any judicial proceeding and/or current criminal charges now pending (not counting traffic violations or offenses prior to 18 <sup>th</sup> birthday)			
Ever had a restraining order issued against them?			

***A Criminal History Clearance (may include PA and/or FBI clearances) and Child Abuse Clearance must be completed as part of the application process.***

Would you consent to us contacting FBI, local and state police for a reference? (Check)      **YES**      **NO**

***Agreement:***

\_\_\_\_\_ The information on this application is true to the best of my knowledge. I understand that any false statement or omission of material/fact may disqualify me from further consideration from becoming a Lifeshare Provider.

\_\_\_\_\_ I understand the information shared on this application is solely for the purpose of matching compatibility and determining eligibility as a Lifeshare Provider.

\_\_\_\_\_ I understand that this application is not for agency employment purposes and only for purposes of a potential contract with the agency as a provider of Lifeshare services.

\_\_\_\_\_ I understand that completion of this application does not constitute an agreement for authorization to provide services in your home.

\_\_\_\_\_ I agree to allow a study and inspection to be made of my home to ascertain my qualifications and compliance with Lifesharing Program requirements.

\_\_\_\_\_ I understand that the Lifesharing agency or applicant can discontinue the application process at any time.

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Lifeshare Provider

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Date

*.All information received on this application will be handled with the utmost care and confidentiality.*

**Applications can be mailed or dropped off to our receptionist:**

**Person Directed Supports  
C/O Trish Vecchio  
1541 Alta Drive  
Whitehall, PA 18052**

To Submit to Lehigh  
use this email address:  
*Lehigh@persondirectedsupports.com*

To Submit to Chambersburg  
use this email address:  
*Chambersburg@persondirectedsupports.com*

To Submit to Lancaster  
use this email address:  
*Lancaster@persondirectedsupports.com*