



Respite Care Referral Program
7320 Ritchie Highway
Glen Burnie, MD 21060
(410) 222-4377/4339
respite_care@aacounty.org
www.aacounty.org/aging

Dear Prospective Respite Care Worker:

Thank you for your inquiry regarding the Respite Care Referral Program. Our mission at the Anne Arundel County Department of Aging and Disabilities is to help the ill, disabled, and frail citizens remain in their homes for as long as possible. The Respite Care Referral Program provides a less costly alternative to clients who call seeking home care for themselves or a loved one. The Respite Care Referral Program has been a successful linkage program since 1986 and continues to look for caring, compassionate home care and companion care workers.

In order to qualify to become a member of our referral registry, you must:

- Be a resident of Anne Arundel County;
- Submit a completed application with required background check fee;
- Have a clean background check void of any charges or convictions;
- Demonstrate a minimum cumulative work experience of 3 years within past 5 years;
- Provide two (2) references from current or previous supervisors at time of application. (Family members cannot be used as references);
- Have a valid Maryland driver's license;
- Have personal automobile;
- Provide a copy of work authorization from Homeland Security Administration (non-US Citizens)
- Complete the required training.
- Remit the required training/registry fee (by check or money order) at the time of training.

Please contact your references and inform them they will be receiving a reference form to be completed and request they return it as soon as possible. Do **not** give the form to your references. The Respite Care Referral Program staff will mail this form to ensure authenticity.

Return the following information as soon as possible.

- the completed application packet;
- a copy of your Maryland driver's license; (Driver's license must match mailing address);
- a copy of your motor vehicle registration;
- a money order in the amount of \$10.00 payable to DoAD/NFCSP

After we have received a clear criminal background report and positive references, you will receive a call to schedule training. Please review your application carefully to ensure you have followed all directions. **Incomplete or incorrect applications will be not considered and will be returned to the applicant.**

We appreciate your interest in the Anne Arundel County Department of Aging and Disabilities Respite Care Referral Program and look forward to meeting you in the near future.

Sincerely,

Handwritten signature of Mary Chaput in blue ink.

Mary Chaput, Program Director

Handwritten signature of Dee Scharff in blue ink.

Dee Scharff, Program Coordinator

**RESPITE CARE REFERRAL PROGRAM
WORKER APPLICATION**

Please review your application letter carefully to ensure you have followed all the directions.
Incomplete or incorrect applications will not be considered and will be returned.

PRINT LEGIBLY

Social Security #: _____ Male Female

1. First Name: _____ Middle Name _____ Last Name _____

2. Address (*Must be resident of Anne Arundel County*): **(Street address required with P.O. Box)**

Street Apt. No.

City State Zip Code

3. Phone (home): _____ Cell _____ E-mail _____

4. Date of Birth: _____

5. Have you previously applied to the Respite Care Referral Program? Yes No

6. Have you previously worked with the Respite Care Referral Program? Yes No (If Yes, when _____)

7. Who referred you to the Respite Care program? _____

8. Are you a Certified Nursing Assistant or Patient Care Tech? Yes No. (If Yes, license number # _____.)

Is your certification current in Maryland? Yes No Current through (date): _____

****Note: Registered Nurses (RN) and Licensed Practical Nurses (LPN) are not eligible for this program.**

9. Describe your background interest and /or experience in providing care to people:

10. Do you have a current MD driver's license? Yes No **(Maryland driver's license is required.)**

11. Do you have a reliable car for transportation? Yes No **(Your personal vehicle is required.)**

12. Do you have any physical problems that limit the type of activities you would be able to perform? Yes No

If yes, explain: _____

13. Have you ever been convicted of a crime? Yes No

If yes explain: _____

14. Have you ever been charged with a crime? Yes No

If yes explain: _____

CRIMINAL BACKGROUND INVESTIGATION RELEASE

I hereby authorize ANNE ARUNDEL COUNTY DEPARTMENT OF AGING AND DISABILITIES and Pinkerton Consulting and Investigations, to obtain any information pertaining to my criminal and/or civil court records. I hereby direct Pinkerton Consulting and Investigations to release such information upon request of ANNE ARUNDEL COUNTY DEPARTMENT OF AGING AND DISABILITIES or others representatives of the company.

I hereby fully release and discharge Anne Arundel County, Maryland, it's agents, assigns, employees, officers and volunteers, including the Department of Aging and any other County government source providing information to Respite Referral Registry Program participants from and claims and damages arising out of or relating to any investigation of my background for the purpose of placement on the Respite Care Program Registry. I acknowledge that a telephone facsimile or photograph copy of this release and authorization form and the resulting investigative report shall be valid as the original.

Minimum 7 Years of residential History/Signature Required

PLEASE PRINT CLEARLY

Name: _____ Maiden/Alias: _____ (Last, First, Middle) (Indicate last year alias(es) was used)	
Date of Birth: _____	Social Security#: _____
Driver's License No.: _____	State license issued: _____
Current Address: Street: _____	
City/State/Zip Code: _____	County: _____
Dates at this address: From _____ To _____	
Previous Address: Street: _____	
City/State/Zip Code: _____	County: _____
Dates at this address: From _____ To _____	
Previous Address: Street: _____	
City/State/Zip Code: _____	County: _____
Dates at this address: From _____ To _____	
Signature: _____ Date: _____	

APPLICANT'S REFERENCE FORM

RESPITE CARE REFERRAL PROGRAM

TO BE COMPLETED BY APPLICANT:

My signature is authorization for you to release information regarding my employment to the Anne Arundel County Respite Care Referral Program relative to my application for the Respite Care worker registry.

Applicant's Printed Name _____

Applicant's Signature _____ Date _____

Family members cannot be named as references.

Supervisor's Name: _____

Place of Employment: _____ Start Date _____ End Date _____

Mailing Address: Street _____ City/State/Zip _____

Reference Telephone: _____ Fax: _____

THE RESPITE PROGRAM WILL MAIL YOUR REFERENCES TO THE PERSON LISTED. DO NOT SEND THE RESPITE CARE REFERRAL PROGRAM COMPLETED REFERENCE FORMS. COMPLETE THIS SECTION ONLY.

The Anne Arundel County Department of Aging and Disabilities maintains a Respite Care Referral list of self-employed workers who provide in-home care for elderly clients. The applicant signing this form has given your name as a reference. Please complete the reference information and return in the self-addressed envelope or fax to 410-222-7015 as soon as possible. Thank you for your assistance.



The section below must be mailed to your reference by the Respite Care Referral Program. Applicants must NOT have this section completed with the application.

TO BE COMPLETED BY REFERENCE

1. How well do you know the applicant? Slightly Well Very Well
2. Are you, or have you been, the applicant's Supervisor/Employer? Yes No
3. Have you had any knowledge of the applicant within the past twelve months? Yes No

Please rate the applicant on the following:

- | | | | | |
|-------------------|--|----------------------------------|--|---------------------------------------|
| 1. Dependability | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average | <input type="checkbox"/> No Knowledge |
| 2. Judgment | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average | <input type="checkbox"/> No Knowledge |
| 3. Responsibility | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average | <input type="checkbox"/> No Knowledge |
| 4. Overall Rating | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average | <input type="checkbox"/> No Knowledge |

Comments:

Reference Signature _____ Date _____

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Comments:

Reference Signature _____ Date _____