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|  | **Companion Home Outside Employment Notification and Review** | | | | | |  |
|  |  | | | | | | DATE |
| COMPANION HOME PROVIDER NAME | | | | | | COMPANION HOME CONTRACT NUMBER | |
| COMPANION HOME ADDRESS | | | | | | | |
| CLIENT SUPPORTED | | | | | | | CONTRACT START DATE |
| NAME OF (CURRENT OR PROPOSED) OUTSIDE EMPLOYER | | | | | HOURS PER WEEK | | DATE OF EMPLOYMENT |
| ADDRESS OF OUTSIDE EMPLOYER (PHYSICAL ADDRESS) CITY STATE ZIP CODE | | | | | | | |
| JOB TITLE | | | | LOCATION OF EMPLOYMENT | | | |
| New outside employment  Currently engaged in outside employment  Annual Review | | | | | | | |
| DESCRIPTION OF DUTIES | | | | | | | |
| YES NO  1. Does the outside employment involve direct service for children or vulnerable adults?  2. Does the outside employment involve the provision of care or supervision of a child or vulnerable adult   in your home?  3. Is the employer licensed or contracted with DSHS?  4. Has the employer been informed of your commitment as a contracted companion home provider?  5. Has the employer been informed that as a 24/7 residential provider you may need to leave in the event   of a crisis with little to no notice given?  6. Who will provide direct service support to the companion home client during outside employment work hours? | | | | | | | |
| Explain ALL of your YES answers: | | | | | | | |
| **I understand that this notification and review of outside employment will be made a part of my contract file.** | | | | | | | |
| COMPANION HOME PROVIDER OR APPLICANT SIGNATURE | | | | | | | DATE |
| **Resource Manager Review** | | | | | | | |
| No Conflict  Conflict\*\* | | RESOURCE MANAGER’S SIGNATURE | | | | | DATE |
| **Regional Administrator or Designee Review** | | | | | | | |
| No Conflict  Conflict\*\* | | REGIONAL ADMINISTRATOR OR DESIGNEE’S SIGNATURE | | | | | DATE |
| **\*\* To be completed by the Companion Home (CH) Provider or Applicant if a conflict is identified.** | | | | | | | |
| I choose to terminate my outside employment.  I choose to terminate my CH contract. | | | CH PROVIDER OR APPLICANT’S SIGNATURE | | | | DATE |
| **For DDA Use Only** | | | | | | | |
| REVIEWED WITH PROVIDER / APPLICANT AND WITNESSED BY: | | | | | | | DATE |
| CH PROGRAM MANAGER REVIEW SIGNATURE | | | | | | | DATE |