May 2018

Employment Experience Form

Competency-Based Training and Longevity Rate Add-on for Providers of HPC Services

Applicant's name	Applicant's DOB	Application number

Employer name: List either the name of the agency through which you were employed or the name of the person you served as an independent provider.

Street Address, City, State: Specify the address of the employer.

Job title: List the title you had while employed by an agency. For all services delivered as an independent provider, write "independent provider". Additional documentation, such as pay stubs or employment verification on agency letterhead, must be submitted for each agency employer listed.

Services provided: Describe the type of waiver service provided, such as Homemaker/Personal Care, Shared Living, employment services, etc., or other service specifically for people with developmental disabilities.

Dates of service: Include day, month, and year on which employment started and stopped for this employer.

Total Hours: Include number hours worked each week for the employment span if working for an agency or include the total number of units or hours billed as an independent provider.

Employer name, street address, city, state	Job title	Services provided	Dates of service	Total hours

I certify that the information provided above is accurate. I understand that falsifying any information on this document may result in a denial or revocation of certification.

Applicant's printed name	Applicant's signature	Date

Ohio Department of Developmental Disabilities

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