2001 Hoyt Street,
Lakewood, CO 80215

We do not discriminate on the basis of race, color, religion, national origin, sexual orientation, age, gender expression, disability, marital status, military status, or any other status protected by law or regulation. It is our intention that all qualified applicants are given equal opportunity and that selection decisions be based on job-related factors.

To process your application each question must be answered fully and accurately. Questions left blank will delay further processing of your application. Use blank paper if you do not have enough room on this application. In reading and answering the following questions, be aware that none of the questions are intended to imply illegal preferences or discrimination based upon non-job-related information.

PLEASE PRINT, except for the signature on back of application.

Today's Date: _____/_____/_____ Job Applied For: _____ Expected Salary: $_____

Are you seeking: ☐ Full-time ☐ Part-time ☐ Intern
Shift Desired: ☐ Days ☐ Evening ☐ Weekends
Work Preference: ☐ Center Based Services ☐ Home Based Services Intermittent Visits ☐ FFS Center ☐ FFS Home Based

Last Name	First Name	Middle Name	
Present Street Address	City	State	Zip Code
Telephone Number	Alternate Telephone Number	Social Security Number	

Are you 18 years of age or older? Yes □ No □ (If you are hired, you may be required to submit proof of age)

If hired, can you furnish proof that you are eligible to work in the U.S. ? Yes □ No □

Were you ever employed here? Yes □ No □ If yes, when? _____ (time frame)

Have you ever worked or attended school under any other name(s)? Yes □ No □ If yes, give name(s)

_____

Military Experience: Yes □ No □ Branch of Service: _____Dates of Service_____

FEDERAL AND STATE HEALTH CARE PROGRAM INQUIRY:

All applicants for employment at Firefly Autism, Inc. are asked to self identify as an ineligible person from participating in Federal or State health care programs. Please answer the following questions:

Are you currently excluded from participation in any Federally or State funded healthcare programs including Medicare and Medicaid and are you aware of any potential exclusion from a Federally or State funded health program? Yes _____ No _____

If employed, I agree to immediately disclose to the company any department, suspension, exclusion or other event that makes me ineligible to participate in any federal or state health care programs or receive a government contract. Yes _____ No _____

EDUCATIONAL SKILLS AND ACHIEVEMENTS

(You must be prepared to provide proof of any educational achievements entered on this form)

List Name and Address of Schools

High School or GED ____________________________ No. of years completed ______ Diploma Yes ☐ No ☐

College or University ___________________________ No. of years completed _______ Degree Completed ___________________

Vocational or Technical _________________________ Training completed ________________________ Certificate Yes ☐ No ☐

What skills or additional training do you have that are related to the job for which you are applying?

____

____

EMPLOYMENT HISTORY – *Note: A job offer may be contingent upon acceptable references from current and former employers*

Most Current: Company and Address	From	To	Position Held	Supervisor
				May we contact this employer? Yes ☐ No ☐
Phone Number (Include Area Code)	Final Rate of Pay $		Reason for leaving	Eligible for rehire? Yes ☐ No ☐
Most Current: Company and Address	From	To	Position Held	Supervisor
				May we contact this employer? Yes ☐ No ☐
Phone Number (Include Area Code)	Final Rate of Pay $		Reason for leaving	Eligible for rehire? Yes ☐ No ☐
Most Current: Company and Address	From	To	Position Held	Supervisor
				May we contact this employer? Yes ☐ No ☐
Phone Number (Include Area Code)	Final Rate of Pay $		Reason for leaving	Eligible for rehire? Yes ☐ No ☐
Most Current: Company and Address	From	To	Position Held	Supervisor
				May we contact this employer? Yes ☐ No ☐
Phone Number (Include Area Code)	Final Rate of Pay $		Reason for leaving	Eligible for rehire? Yes ☐ No ☐

I certify that all information provided in this employment application is true and complete. I understand that any false information or omission may disqualify me form further consideration for employment and may result in my dismissal if discovered later. I authorize Firefly Autism and/or its representatives whether listed or not to conduct a thorough investigation of my background including any school, current employer, past employers, government and law enforcement agencies and licensing boards to provide relevant information an opinion regarding my background that may be useful in making a hiring decision. I release such persons and organizations form any legal liability in making such statements. I agree that Firefly Autism shall not be liable in any respects if my employment is terminated because of falsifications, misstatements or omissions made by me, including my physical capability to do the work for which I am applying. ***Any applicant who knowingly or willfully makes a false statement of any material fact or thing in the application is guilty of perjury in the second degree in section 18-8-503, C.R.S., and upon conviction thereof, shall be punished accordingly.*** I consent to the release of any or all medical information as may be deemed necessary to judge my capability to do the work for which I am applying, if required. I hereby consent to a pre or post employment drug screen as a condition of employment. I further understand that this application, verbal statement by management, or subsequent employment does not create an express or implied contract of employment nor guarantee employment for any definite period or time. If employed, I understand that I have been hired at the will of the employer and my employment may be terminated at any time, with or without reason and with or without notice. I have read, understand, and by my signature consent to the above statements.

Signature: _____ Date: _____

Health Status Assessment Notification

I understand that by my signing said application, that my signature constitutes verification that I am free from any health impairment and/or physical restrictions which is of potential risk to the client, family, or to employees or that may interfere with the performance of my duties as described in my job description.

Signature: _____ Date: _____

DRUG AND ALCOHOL POLICY AGREEMENT

It is Firefly Autism's policy to provide a drug-free, healthful, and safe workplace. To promote this goal, employees are required to report to work in an appropriate mental and physical condition to uphold an environment that demonstrates a commitment to quality treatment integrity.

While on the company premises and while conducting business-related activities off the company premises, no employee may use, possess, distribute, sell, or be under the influence of alcohol or engage in the unlawful manufacture, distribution, dispensation, possession, or use of illegal drugs. Violations of this policy may lead to disciplinary action, up to and including immediate termination of employment. Such violations may also have legal consequences.

The legal use of prescribed drugs is permitted on the job only if it does not impair an employee's ability to perform the essential functions of the job effectively and locked safely in your personal vehicle so as not to endanger the client or other individuals in the workplace. The employee must notify management of such prescribed drugs before reporting to their assigned workplace, for appropriate analysis of the employees fit for duty.

All information that may be received from the applicant regarding prescription and/or non-prescription drug use and health conditions will remain confidential within the Employee Health File.

Worker's servicing clients and suspected of violating company drug and alcohol policy would be required to take a drug and alcohol test conducted by Firefly Autism designated medical laboratory testing facility within 24-hour period of suspected violation. Any confirmed abuse will be grounds for immediate termination. Any refusal to take a drug and alcohol test will be treated as grounds for termination.

Under the Drug-Free Workplace Act, an employee who performs work for a government contract or grant must notify the company of a criminal conviction or receiving notice of the conviction for drug-related activity occurring outside the workplace. The report must be made within five days of the conviction.

I hereby understand that by my signing said application, I consent to testing, when requested, for substance abuse screening conducted by Firefly Autism designated medical laboratory testing facility in accordance with Firefly Autism policies and procedures, and thereby agree to maintain company policy to provide a drug-free, healthful, and safe workplace.

Signature: _____ Date: _____

APPLICANT EEO OR AFFIRMATIVE ACTION INFORMATION

It is the policy of this organization to provide equal employment opportunity to all qualified applicants for employment without regard to race, color, religion, national origin, sex, age, veteran status, or disability. Various agencies of the government require employers to invite applicants to identify themselves as indicated below.

COMPLETION OF THIS FORM IS VOLUNTARY AND IN NO WAY AFFECTS THE DECISION REGARDING YOUR APPLICATION FOR EMPLOYMENT. THIS FORM IS CONFIDENTIAL AND WILL BE MAINTAINED SEPARATELY FROM YOUR APPLICATION FORM.

Please Print

NAME: _____ Date: _____
Last First Middle

SEX: Male Female

WHAT IS YOUR RACE/ETHNICITY ORIGIN?

(0) White

(1) Black (not of Hispanic origin)

(2) Asian/Pacific Islander

(3) American Indian / Alaskan Native

(4) Hispanic

(5) Other

WHERE DID YOU HEAR ABOUT THIS JOB?

(1) Social Network

(2) Walk-In

(3) Employee Referral Name: _____

(4) State Employee Office

(5) Community Referral

(6) Other _____

Position Applied For: _____

Are You a Vietnam Era Veteran? Yes No
A person who served on active duty for a period of more than 180 days any part of which occurred between 8/5/1964 and 5/7/1975, and was discharged or released therefrom with other than a dishonorable discharge or for a service connected disability.

Are you Disabled Veteran? Yes No
A person entitled to disability compensation under laws administered by the Veterans Administration for disability rated at 30% or more, or a person whose discharge or release from active duty was for a disability incurred or aggravated in the line of duty.

Do you have a mental or physical disability? Yes No
A person who has a mental or physical impairment that substantially limits one or more major life activities, who has a record of such impairment, or who is regarded as having such an impairment.

FOR HUMAN RESOURCES USE ONLY