

RESOURCE, SUPPORT, AND DEVELOPMENT, INC.
R.S.D., INC.
PO BOX 80185 * BILLINGS, MT 59108-0185
Phone: 406-652-5443 Fax: 406-652-9361
SATELLITES: BILLINGS, RED LODGE, LEWISTOWN, HARDIN

SKILLS/EXPERIENCE

FOR EACH OF THE SKILLS/EXPERIENCE LISTED BELOW, INDICATE WHICH OF THESE HAS BEEN A SIGNIFICANT PART OF YOUR PAST EMPLOYMENT OR TRAINING.

A. SUPERVISORY EXPERIENCE

- REPORT WRITING
- BUDGETING
- PUBLIC RELATIONS
- STAFF DEVELOPMENT
- HIRING
- EVALUATING STAFF
- CONFLICT MEDIATION
- PROGRESSIVE DISCIPLINE
- SCHEDULING STAFF
- QUALITY CONTROL OF STAFF

B. CONSUMER CARE

- WORKING UNSUPERVISED
- EXPERIENCE WITH WHEELCHAIRS & OTHER ADAPTIVE EQUIPMENT
- MEDICATION SUPERVISION
- PERSONAL CARE
- HANDLING EMERGENCIES
- MENU PLANNING/COOKING/GROCERY SHOPPING
- PLANNING/TRAINING RECREATIONAL & LEISURE ACTIVITIES
- WORKING WITH FAMILIES OR PARENTS
- COUNSELING SKILLS
- SOCIAL SERVICE NETWORKING

C. CONSUMER TRAINING

- WRITING INDIVIDUAL PROGRAM PLANS
- IMPLEMENTING TRAINING PROGRAMS
- WRITING SHORT & LONG RANGE GOALS
- CONDUCTING ASSESSMENTS
- DATA COLLECTION
- PRINCIPLES OF BEHAVIOR THEORY
- NON-AVERSIVE BEHAVIOR MANAGEMENT
- CONSUMER RIGHTS
- PREPARATION OF IP'S
- EXPERIENCE WITH ALTERNATIVE METHODS OF COMMUNICATION
- SELF-HELP SKILLS
- SOCIAL SKILLS
- JOB COACHING

D. FACILITY/EQUIPMENT/VEHICLE MAINTENANCE

- EXPERIENCE WITH LIFT EQUIPPED VEHICLES
- REPAIR AND MAINTENANCE
- YARD WORK
- HOUSEKEEPING
- SAFETY STANDARDS

E. OTHER

- MARKETING
 - ACCREDITATION STANDARDS
 - CPR/FIRST AID
 - MANDT TRAINING
 - DDCPT CERTIFICATION OR EQUIVALENT
 - OFFICE SKILLS (LIST BELOW)
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I CERTIFY THAT THE FACTS IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSE OR MISLEADING STATEMENTS OR OMISSIONS ON THIS APPLICATION SHALL BE A BAR TO BEING HIRED OR, IF DISCOVERED AFTER HIRING MAY LEAD TO TERMINATION. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED HEREIN AND THE REFERENCES LISTED ABOVE TO GIVE YOU ANY AND ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT AND ANY PERTINENT INFORMATION. I RELEASE ALL PARTIES FROM ALL LIABILITY FOR ANY DAMAGE THAT MAY RESULT FROM FURNISHING SAME TO YOU.

APPLICANT'S SIGNATURE

DATE

IT IS THE POLICY OF R.S.D., INC. TO GIVE EQUAL OPPORTUNITY TO ALL QUALIFIED PERSONS WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX, MARITAL STATUS, HANDICAP, NATIONAL ORIGIN, OR SEXUAL ORIENTATION. REASONABLE ACCOMMODATIONS WILL BE MADE AS NEEDED. R.S.D., INC. MAINTAINS A DRUG FREE WORKPLACE.

NOTE: THIS APPLICATION WILL BE KEPT ON FILE FOR THREE MONTHS. AFTER THAT TIME A NEW APPLICATION WILL BE REQUIRED TO REAPPLY FOR ANY OPEN POSITIONS.

PROVIDING SERVICES TO INDIVIDUALS WITH DISABILITIES IN BILLINGS, HARDIN, LEWISTOWN,
AND RED LODGE, MONTANA

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REFERENCE RELEASE AUTHORIZATION

I am applying for a job at Resource, Support, and Development, Inc. (R.S.D., Inc.), which provides group home and vocational services for persons with developmental disabilities. I understand that the goal of R.S.D., Inc. is to provide quality care, and therefore, has the responsibility to hire competent personnel of good character and personal integrity.

I understand that, in order to make a knowledgeable decision regarding my application for employment, the administrative staff of R.S.D., Inc. must contact my previous employers, references and law enforcement agencies.

I therefore authorize Resource, Support, and Development, Inc. to investigate my past record and to ascertain any and all information which may concern my record and character, whether same is of record or not, and I hereby release all persons whomsoever from any damage because of furnishing this information. I understand that contacts may be made with any of the following: employers, courts, law enforcement, agencies, social services and any other persons or agencies I with whom I have had contact.

**PLEASE COMPLETE THE FOLLOWING INFORMATION AS IT APPEARS ON YOUR
MONTANA DRIVER'S LICENSE:**

LAST NAME

FIRST NAME

MIDDLE

STREET ADDRESS OR PO BOX

CITY

STATE

ZIP CODE

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DRIVER'S LICENSE #

MALE

FEMALE

ADDITIONAL INFORMATION:

MAIDEN NAME

NICKNAME OR AKA

SIGNATURE OF APPLICANT

DATE

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**Customer Services Bureau
Records Management Section
PO Box 201403
303 N. Roberts, 4th Floor
Helena, MT 59620-1403**

As part of the initial application process Resource, Support, and Development, Inc. is required to complete a record check on all potential employees. Please release any information you may have on the individual listed below to:

CORPORATION

PROGRAM

ADDRESS

PROGRAM MANAGER'S SIGNATURE

DATE

A self-addressed stamped envelope is enclosed.

PLEASE COMPLETE A RECORD CHECK ON THE FOLLOWING APPLICANT:

LAST NAME

FIRST NAME

MIDDLE NAME

MAIDEN NAME

NICKNAME

OR

AKA

DATE OF BIRTH

MALE FEMALE

SOCIAL SECURITY NUMBER

I HEREBY AUTHORIZE ANY LAW ENFORCEMENT AGENCY OR THE MONTANA DEPARTMENT OF MOTOR VEHICLE DIVISION TO RELEASE ANY RECORDS THEY HAVE REGARDING ME TO THE CORPORATION LISTED ABOVE.

Signature of Applicant

Date

STATE OF MONTANA
Department of Public Health and Human Services
Quality Assurance Division

RELEASE OF INFORMATION (For Licensed Youth and Adult Care Providers)
Criminal and Protective Service Background Checks

PLEASE TYPE OR PRINT LEGIBLY

Section A

Facility Name: _____ Facility Location: _____

Actual or prospective dates of hire at facility: _____

Applicant's Name: _____
First Middle Maiden Last

Aliases/Other Names Used:

Applicant's Current Address: _____

Phone #: _____ Date of Birth: _____ Sex: { } M { } F

Drivers License #: _____ Social Security #: _____

Section B

Please list below where you have resided in the past 5 years. Attach additional pages if necessary.

City	County	State	Dates of Residency (From To)

Section C

I understand that any information obtained from these checks will be used by the Department to evaluate my employer's application or my own application as a licensed provider. I hereby authorize any law enforcement, protective services agency or the Montana Motor Vehicle Division to release any records they have regarding me to the State of Montana, Department of Public Health and Human Services and (if applicable) to my employer or perspective employer as indicated in Section A of this form.

A copy of this form is as valid as the original.

Signed: _____ Date: _____
To be signed in front of a Notary

To be completed by Notary Public:

Taken, sworn and subscribed before me this _____ day of _____ A.D. 20 _____

Notary Public for the State of Montana Residing at: _____ My Commission Expires: _____

RETURN TO: TRISH STROMAN, OFFICE MANAGER
CHILD & FAMILY SERVICES
P.O. BOX 8005
HELENA, MT 59604-8005