LizMedCare

LIZMEDCARE LLC

NJ DDD Approved Service Provider
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APPLICATION FOR EMPLOYMENT & SERVICE REFERRAL INQUIRY

Direct Support Professional (DSP) & Participant Service Intake Form

Instructions: Complete **Part A** for Employment (DSP Job Applicant) or **Part B** for Participant/Family Service Referrals.
All applicants/representatives must sign **Part C** on Page 2.

PART A: DIRECT SUPPORT PROFESSIONAL (DSP) EMPLOYMENT APPLICATION

SECTION 1 — APPLICANT PERSONAL INFORMATION

Full Legal Name:	_____		
Other Names Used:	_____	**Date of Birth:**	MM / DD / YYYY _____
Street Address:	_____		
City / State / Zip:	_____	**County of Residence:**	County name _____
Phone Number:	_____	**Email Address:**	name@example.com _____
U.S. Work Authorization:	☐ Yes, eligible to work in U.S. ☐ No		*(SSN collected separately via secure background authorization)*

SECTION 2 — EMERGENCY CONTACTS

Contact Name	Relationship	Phone Number	Alternate Phone
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 3 — POSITION AND AVAILABILITY

Position Applied For:	**Direct Support Professional (DSP)**		
Preferred Services:	☐ Individual Supports ☐ Community Based Supports ☐ Community Inclusion Services		
Employment Type:	☐ Full-Time ☐ Part-Time ☐ Per Diem	**Date Available:**	MM / DD / YYYY _____
Preferred Counties:	☐ Middlesex ☐ Monmouth ☐ Ocean ☐ Union ☐ Essex ☐ Somerset		

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Valid Driver's License?	☐ Yes ☐ No	**State / Exp Date:**	_____
Personal Vehicle Available?	☐ Yes ☐ No	**Auto Insurance Active?**	☐ Yes ☐ No
Willing to Transport?	☐ Yes, willing to transport participants ☐ No		

RECENT WORK EXPERIENCE (DIRECT CARE / HEALTHCARE PREFERRED)		
Employer & Location	**Position & Dates**	**Reason for Leaving**

Mandatory NJ DDD Compliance Acknowledgments	Initials
Criminal Background & Fingerprinting: I consent to background screening and fingerprinting as mandated by NJ DDD regulations.	
CARI Check: I consent to Child Abuse Record Information (CARI) background verification through NJ DCF.	
Drug Screening & Mandatory Reporting: I agree to pre-employment drug screening and acknowledge mandatory reporting duties regarding abuse, neglect, or exploitation.	

PART B: PARTICIPANT SERVICE INQUIRY (NJ DDD REFERRALS)

PARTICIPANT INFORMATION			
Participant Full Name:		**DOB (Participant):**	MM / DD / YYYY
Medicaid ID #:		**DDD ID #:**	DDD ID number
Support Coordination Agency:		**Coordinator Name:**	First and last name
Coordinator Email / Phone:			
Services Requested:	☐ Individual Supports ☐ Community Based Supports ☐ Community Inclusion Services		

PART C: LEGAL ATTESTATION & AUTHORIZATIONS

I certify that all information provided in this application/inquiry is true, accurate, and complete to the best of my knowledge. I understand that false statements or omissions may result in rejection of application or termination of employment/service agreement. I authorize LizMedCare LLC to verify all credentials, work history, references, and conduct required NJ DDD background checks.

Applicant / Legal Guardian Signature

Date

Printed Full Name

FOR OFFICE USE ONLY			
Date Received: _____	Reviewed By: _____	CARI/Background Initiated: [ ]	DDD Status Verified: [ ]