NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

Consent for Release of Employment Information for OPWDD Family Care Program

Date:

Dear _____:

Your employee, _____, has submitted an application to provide services to individuals with intellectual or developmental disabilities as part of the Office for People With Developmental Disabilities' (OPWDD) Family Care program.

Please assist us in evaluating this potential applicant by completing the attached form and returning it in the enclosed envelope. This information will be held in confidence.

Your prompt attention and assistance is greatly appreciated.

Sincerely,

I, _____, hereby authorize and consent to the release of
(Applicant/Provider)

confidential information by _____, _____
(Employer's Name) (Employer's Phone Number)

_____
(Employer's Address)

to _____.
(Sponsoring Agency)

_____ _____
Applicant Signature Date

NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

Employment Reference for OPWDD Family Care Program

Applicant's Name: _____

1. Is the applicant currently employed by your organization? _____

    a. If not currently employed, list date of separation: _____

2. How long has the applicant been employed by your organization and in what capacity?

3. Has the applicant's attendance been satisfactory? Please explain.

4. Would you consider the applicant reliable? Please explain.

5. Does the applicant work well with others? Please explain.

6. If there is any other information you would like us to consider, please explain below.

_____ _____
Printed Name/Title of Person Completing Form Date

_____ _____
Signature of Person Completing Form Phone Number