@HomeTherapy, PT, OT
Adult Physical & Occupational Therapy
In The Comfort Of Your Home

71-20 110th Street
Forest Hills, NY 11375
P 718-305-1190
F 718-305-1191
athomeptot@gmail.com

CONTRACTOR APPLICATION

NAME: _____ **SS#:**_____
(First, Complete Middle, Last)
BIRTH CITY, STATE, COUNTY: _____ **DATE OF BIRTH:** ____/_____/_____ **SEX:** ☐MALE ☐FEMALE

DEGREE: _____

HOME ADDRESS: _____

HOME PHONE #: _____ **CELL PHONE #:** _____

FAX #: _____ **E-MAIL ADDRESS:** _____

Are you eligible to work in the U.S.? ☐ Yes ☐ No

Status: ☐ U.S. Citizen ☐ Permanent Resident ☐ Work Authorization ☐ H1-B

MEDICAL SCHOOL: _____ **YEAR OF GRADUATION:** _____

LICENSE #: _____ **LICENSE FIRST ISSUED:** _____ **EXPIRATION DATE:** _____

MEDICARE # (IF ISSUED):_____ **MEDICAID # (IF ISSUED):**_____

PROFESSIONAL SOCIETY MEMBERSHIPS: _____

NPI# _____ **IF YOU DO NOT HAVE AN NPI NUMBER, WE WILL BE GLAD TO APPLY FOR ONE FOR YOU**

HAVE YOU EVER BEEN CONVICTED OF ANY CRIMES: ☐YES ☐NO
IF YES, PLEASE EXPLAIN: _____

_____

Geographic Preference

☐ Brooklyn ☐ Long Island

☐ Queens ☐ Nassau

☐_____

Competencies

☐ *CPR*
☐ *Nursing Home Experience*
☐ *Outpatient Experience*
☐ *Bilingual* _____*(Language)*

References:

1. **Name** _____
Profession:_____
Facility:_____
Phone:_____
Email:_____

2. **Name** _____
Profession:_____
Facility:_____
Phone:_____
Email:_____

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Background Check Disclosure Form

In processing my application to secure work assignments through @Home Therapy, PT, OT, I understand that @Home Therapy, PT, OT may obtain reports regarding criminal background, work exclusions as well as verification of licensure status. Agencies contacted may include, but may not be limited to:

- ***HHS Office of the Inspector General Exclusions Website***
- ***New York State Office of the Professions – License Verification***
- ***ASI New York State Nursing Home Aide Registry***
- ***New York State Department of Health State Central Registry***

By signing below I am authorizing @Home Therapy, PT, OT to carry out such background checks.

I further acknowledge that a telephone facsimile or photographic copy of this release will be valid as the original.

I, the undersigned, hereby certify under penalty of perjury that I am duly authorized to submit this application and that the information contained herein and attached hereto is accurate, true and complete. I understand that if I knowingly give false statements such actions could be grounds for denial or dismissal.

Signature: _____ Date: _____

DATE _____

REVIEWED BY: _____

REFERRED BY: _____

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PLEASE ATTATCH A COPY OF THE FOLLOWING:

1. _____ **RESUME**
2. _____ **CURRENT REGISTRATION CERTIFICATE**
3. _____ **PROFESSIONAL LICENSE (copy of each page)**
4. _____ **MALPRACTICE INSURANCE**
5. _____ **EACH DEGREE/CERTIFICATE (COLLEGE AND PROFESSIONAL)**
6. _____ **TWO (2) LETTERS OF RECOMMENDATION**
7. _____ **CE CREDITS RECEIVED WITIHN THE LAST (3) YEARS**
8. _____ **COPY OF SOCIAL SECURITY CARD**
9. _____ **COPY OF PHOTO I.D. (DRIVERS LICENSE OR PASSPORT)**
10. _____ **COMPLETE PHYSICAL**
11. _____ **PPD & MMR**

IMPORTANT NOTICE:
BEFORE YOU START WORKING

- In order to start working we must receive the above documentation.
- Physical, PPD, MMR **MUST BE** submitted to the credentialing department BEFORE you start working.

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OCCUPATIONAL AND PHYSICAL THERAPY COMPETENCY SELF ASSESSMENT

Therapist's Name: _____ **Date: _____**

____ OT ____ PT ____ OTA ____ PTA

Below is a list of clinical competencies in the field of occupational or physical therapy. Please check off your skill level in each of the areas listed.

		SKILL LEVEL		
ADULTS SPECIALTIES	**COMPETENCY**	**LIMITED COMPTENCY**	**NO EXPERIENCE**	**YEARS OF EXPERIENCE**
Orthopedic				
Visual Deficits				
Neurological				
Hands				
Sports Injuries				
Developmental Delays				
Other Physical Disabilities				
Mental Health				
Geriatric				
Cardiovascular/Pulmonary				
Cardiac				
Traumatic Brain Injury				
TREATMENT SKILLS				
General Modalities - List special skills: _____ _____ _____				
Electro physiologic - List skills: _____ _____ _____				
Neurodevelopmental				
Cognitive/Perceptual Training				
Splinting				
Sensory Integration				
Oral Motor Training				
Home/Work Adaptations				
ABA (Applied Behavioral Analysis)				
RDI/Floor time				
Assistive Technology				

DOCUMENTATION SKILLS	**COMPETENCY**	**LIMITED COMPETENCY**	**NO EXPERIENCE**	**YEARS OF EXPERIENCE**
NYC E.I. Documentation				
MDS 2.0 Long Term Care Documentation (Rehab Sections)				
Home Care Documentation				
Individual Education Plan (IEP)				
OASIS Comprehensive Assessment				

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Program Development				
Pediatric Progress Documentation				
OTHER SKILLS				
Knowledge of Medicare Reimbursement				
Proficiency in Language (other than English) List: _____				
Knowledge of current policies, laws and regulations				

STANDARDS FOR CONTINUED COMPETENCY	COMPETENCY	LIMITED COMPETENCY	NO EXPERIENCE	YEARS OF EXPERIENCE
Standard 1: Knowledge Practitioner demonstrates understanding and knowledge of treatment, documentation and legal and regulatory issues.				
Standard 2: Critical Reasoning Practitioner is able to make sound judgments and decisions.				
Standard 3: Interpersonal Abilities Practitioner will develop and maintain professional relationships with others within the context of their roles.				
Standard 4: Performance Skills Clinician will demonstrate expertise and abilities to competently fulfill their role by using proper core resources, technology and current research, pertinent to their discipline and role expectations.				
Standard 5: Ethical Reasoning Clinician will identify, analyze and clarify ethical issues of dilemmas in order to make responsible decisions.				

LIST CONTINUING ED. COURSES ATTENDED IN THE LAST 3 YEARS
1 -
2 -
3 -
4 -
5 -

Therapist's Signature: _____ **Date:** _____

Received By: _____ **Date:** _____