Guthrie Mainstream Services LLC
6549 East University Drive
Mesa, AZ 85205
Phone: 480-633-8881   Fax: 480-633-7095

REFERENCE REQUEST

APPLICANT

This reference request should be provided to a person who has personal knowledge about your education and/or character and can attest to your ability to provide services. Three references are required and they **CANNOT** be from family members. Please fill in your name below and give to the person you are requesting a reference from.

APPLICANT'S NAME *(Last, First, MI)*

APPLICANT'S ADDRESS *(No., Street, City, State, ZIP)*   APPLICANT'S PHONE NO.

(   )   -

PERSON PROVIDING REFERENCE

Please complete the questions listed below keeping in mind that Home and Community Based Services (HCBS) may be performed unsupervised in the home of the person with developmental disabilities or in the residence/facility of the applicant. Your time and effort in completing this form is appreciated and strict confidentiality in regard to your responses will be observed within the provisions of the law.

If mailed, this reference request must be returned to Guthrie Mainstream Services, ATTN: Training Department.
This reference request can also be returned by email to: training@gmsaz.org

PRINT PERSON'S NAME PROVIDING REFERENCE *(Last, First, MI)*

ADDRESS *(No., Street, City, State, ZIP)*

DAYTIME PHONE NO.   EVENING PHONE NO.
(   )   -   (   )   -

STATE THE LENGTH OF TIME YOU HAVE KNOWN THE APPLICANT
Years: Months:

TYPE OF ACQUAINTANCE *(Check all that apply)*

☐ Worked with applicant   ☐ Friend   ☐ Neighbor   ☐ Other:

INDICATE YOUR FEELINGS ON HOW YOU BELIEVE THE APPLICANT WILL RELATE TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES.   DESCRIBE YOUR KNOWLEDGE OF ANY CHARACTERISTICS AND/OR SPECIAL TRAINING/EDUCATION THAT THE APPLICANT MAY HAVE FOR WORKING WITH THESE INDIVIDUALS.

INDICATE IF YOU HAVE ANY REASON TO BELIEVE THAT THE APPLICANT WOULD NOT BE SUITED TO PROVIDE SERVICES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES.

ADDITIONAL COMMENTS WHICH WILL HELP IN EVALUATING THIS APPLICANT

SIGNATURE OF PERSON PROVIDING REFERENCE   DATE

FOR OFFICE USE ONLY

INTERVIEWED BY PHONE   DATE

☐ No   ☐ Yes

INTERVIEWER'S PRINTED NAME *(Last, First, MI)*   INTERVIEWER'S SIGNATURE