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| *This form must be attached to the Delivery Orders for temporary staffing services* | | |
| Administrator: | Department/Division:  Department Number:  Department Internal Number: | |
| Provider: Choose an item. | DO Number: | |
| State Identified Resource: Choose an item.  Name of Individual if known: | Estimated total number of hours to be worked: | |
| Section 1 – Complete if amending existing Delivery Order | | |
| 1. Original Start Date: Current End Date:   Amendment Start Date: New End Date:  Reason:   1. Amount of Adjustment: $ New DO Amount: $   Reason:   1. Amendment to Job Duties or individual performing the duties: 2. Other Reason: | | |
| Section 2 – Complete if new Delivery Order | | |
| Start Date: End Date:  DO Amount: $ | | |
| Why are these services needed at this time?  Briefly summarize the job including the main purpose, objective, and results expected:  Highlight the main duties or key tasks required of the job:  Identify the working relationships associated with the position (i.e.-who the person will report to and if anyone reports to the staff person):  Identify specific qualifications needed to perform the job including: education, experience, training, and technical skills:  Identify the location of where the work will be performed:  Is someone performing these duties currently? Choose an item. If yes, is it under a separate Delivery Order? Choose an item. If yes, provide Delivery Order number: | | |
| Are there any real or perceived conflicts of interest involved with acquiring temporary services from the individual sought? Example: If this is a named resource, does the selected individual have a familial or other pre-existing relationship with anyone in a management capacity in your Department?  Choose an item. If yes, please explain: | | |
| Did the individual named in this temporary service request recently leave State service or hold a position previously with the State? Choose an item. If yes Status: Choose an item.  If Retired and the individual left State service after November 1, 2011, complete 1-13   1. Name of former State employee? 2. Why must this individual return: 3. Dates of employment with the State: 4. Last position held with the State: 5. Last Manager(s): 6. Previous job duties: 7. Last hourly rate: $ 8. Proposed hourly rate: $   Note: the hourly rate being paid to the individual cannot be higher than when they left employment with the State).   1. Proposed term of service: 2. Proposed total hours: 3. Has it been 30 days of the last day of work? Choose an item.   If no, provide justification:   1. Does the DO term exceed 5 years? Choose an item. 2. Is the compensation within the 75% of the compensation established for a classification with equivalent duties and responsibilities? Choose an item. If no, provide justification: | | |
| Department Signature:  Department’s Commissioner or designee must sign the completed form if bringing back a retired State employee | | Date: |

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| **Supplement Information** |

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| Position Title & Name of Individual (if known) | # of Individuals | Staffing  Category | Multiplier | Hourly  Rate | Bill  Rate | # of hours |
|  |  |  |  | $ | $ |  |
|  |  |  |  | $ | $ |  |
|  |  |  |  | $ | $ |  |
|  |  |  |  | $ | $ |  |
|  |  |  |  | $ | $ |  |

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| **CODING** |

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| **LINE TOTAL** | **FUND** | **DEPT** | **UNIT** | **SUB UNIT** | **OBJ** | **PROGRAM** | **PROGRAM PERIOD** | **BOND FUNDING** | **FISCAL YEAR** |
| **$** |  |  |  |  |  |  |  |  |  |

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| **LINE TOTAL** | **FUND** | **DEPT** | **UNIT** | **SUB UNIT** | **OBJ** | **PROGRAM** | **PROGRAM PERIOD** | **BOND FUNDING** | **FISCAL YEAR** |
| **$** |  |  |  |  |  |  |  |  |  |

**(Departments - Attach separate sheet as needed for additional coding.)**

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| **Additional Department Terms: (Use this section as needed. Only this section requires Providers signature)**  Background Checks – The Provider agrees to conduct background checks on all employees, temporary staff persons, persons contracted or hired, consultants, volunteers, students, and other persons who may provide services under this Agreement. The results of each background check shall be made available to the Program Administrator within five (5) days of completion and prior to the person providing services under this agreement. The cost of performing each background check shall be the responsibility of the Provider. The methods of performing the background checks must first be approved by the Department in writing and will include information from the Bureau of Motor Vehicles’, the Sex Offender Registry, and the Maine State Bureau of Investigation. If services to be provided under this agreement include services to minor children than the background check will include information from the Department of Health & Human Services, Office of Child and Family Services regarding allegations of abuse or neglect of a child. If services to be provided under this agreement are to be performed by a person who is professionally licensed, then the background check will include information from the appropriate licensing board or entity regarding the status of the person’s license. The Provider must receive written permission from the Department before making any change to such methods.  The Provider shall not hire or retain in any capacity any person who may directly provide services to client under this Agreement if the person has a record of:   1. Any criminal conviction that involves client abuse, neglect or exploitation; 2. Any criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any reckless conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person within the preceding two years; or 3. Any criminal conviction resulting from a sexual act, contact, touching or solicitation in connection to any victim.   The Provider shall not hire or retain in any capacity any person who may directly provide services to a client who is minor child under this Agreement if that person has a record of substantiated abuse or neglect of a child.  The Provider shall not hire or retain a person to perform any service under this agreement that is required to be performed by a person with an appropriate license unless it has confirmation from the appropriate licensing board or entity that the person has a license in good standing.  Check one of these boxes, as it relates to this Agreement:  The Provider acknowledges and agrees to these additional terms  The candidate is a State Identified Resource; the Department is assuming the responsibility for  the background checks | |
| Invoicing frequency:  Weekly  Every 2 weeks  Monthly | |
| Identify the required duties specifying the outcome based action, object, and purpose:  Include the time expected to be dedicated to each task (if known) – i.e. – 2 hours per day or 130 hours total: | |
| Provider Signature: | Date: |