



APPLICATION FOR EMPLOYMENT

4130 Linden Avenue, Suite 185, Dayton, OH 45432
(937) 221-9783 · careers@utopiatherapeutics.org

Outpatient substance use & mental health · Dayton, Ohio

Utopia Therapeutics is an Equal Opportunity Employer. We do not discriminate on the basis of race, color, religion, sex (including pregnancy, sexual orientation, and gender identity), national origin, age 40 or older, disability, military or veteran status, genetic information, or any other status protected by federal, state, or local law. If you need a reasonable accommodation to complete this application or to take part in any stage of hiring, call (937) 221-9783 or email careers@utopiatherapeutics.org and we will arrange it.

Please answer every question — write “N/A” where one does not apply to you. Do NOT put your Social Security number or date of birth on this form, and do not attach copies of your ID; those are collected only after an offer is made.

1 · POSITION APPLIED FOR

- | | |
|---|--|
| ☐ Clinical Supervisor — LICDC-CS | ☐ Clinical Lead — LISW-S |
| ☐ SUD Counselor / Group Lead — LICDC or LCDC III | ☐ Outpatient Therapist — LPCC |
| ☐ Outpatient Clinician — LSW | ☐ Case Manager — QMHS |
| ☐ Chemical Dependency Counselor Assistant — CDCA | ☐ Certified Peer Recovery Supporter — PRS |
| ☐ Administrative / Front Office | ☐ Other (write below) |

IF “OTHER,” OR A SECOND ROLE YOU'D CONSIDER

DATE YOU CAN START

PAY YOU'RE LOOKING FOR (PER HOUR OR PER YEAR)

Employment type you want (check all that work for you):

- ☐ Full-time ☐ Part-time ☐ Contract / 1099 ☐ PRN — as needed ☐ Student practicum / internship

Hours you are available (check all that apply):

- ☐ Weekday mornings ☐ Weekday afternoons ☐ Weekday evenings ☐ Saturdays

HOW DID YOU HEAR ABOUT THIS POSITION?

DO YOU KNOW ANYONE WHO WORKS HERE? WHO?

Are you legally authorized to work in the United States?

☐ YES ☐ NO

Will you now, or in the future, need Utopia Therapeutics to sponsor an employment visa?

☐ YES ☐ NO

Have you applied to, or worked for, Utopia Therapeutics or Rogan Crosby before?

☐ YES ☐ NO

IF YES — WHEN, AND IN WHAT ROLE?

2 · APPLICANT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	PREFERRED NAME

STREET ADDRESS	APARTMENT / UNIT

CITY	STATE	ZIP

MOBILE PHONE	OTHER PHONE	EMAIL ADDRESS

BEST DAYS AND TIMES TO REACH YOU	HOW SHOULD WE CONTACT YOU — CALL, TEXT, OR EMAIL?

May we send you text messages about your application?

☐ YES ☐ NO

3 · OHIO LICENSURE, CERTIFICATION & CREDENTIALS

Complete every line that applies to you. If you are applying for a role that does not require a license or certification — CDCA, QMHS, Peer Recovery Supporter, or administrative — check “None” and skip to the training line at the end of this section.

☐ LICDC-CS ☐ LICDC ☐ LCDC III ☐ LCDC II ☐ CDCA ☐ LISW-S
☐ LISW ☐ LSW ☐ LPCC-S ☐ LPCC ☐ LPC ☐ IMFT / MFT
☐ QMHS ☐ CPRS (Peer) ☐ RN ☐ LPN ☐ Other (list below) ☐ None / not applicable

Credential 1 — your primary license or certification

CREDENTIAL TYPE	LICENSE / CERTIFICATE NUMBER	ISSUING BOARD (CSWMFT · OCDP · NURSING · OTHER)	STATE

ORIGINAL ISSUE DATE	EXPIRATION DATE	CURRENT STATUS	CE HOURS COMPLETED THIS RENEWAL PERIOD

Credential 2 — any additional license or certification

CREDENTIAL TYPE	LICENSE / CERTIFICATE NUMBER	ISSUING BOARD	EXPIRATION DATE

INDIVIDUAL (TYPE 1) NPI NUMBER	DO YOU HAVE A CAQH PROFILE? ID IF SO	MALPRACTICE CARRIER, IF YOU CARRY YOUR OWN

Has any license or certification you hold or have held ever been denied, suspended, revoked, restricted, placed on probation, or surrendered — or is any currently under investigation — in Ohio or any other state?

☐ YES ☐ NO

IF YES, EXPLAIN FULLY. ATTACH A SEPARATE SHEET IF YOU NEED MORE ROOM.

Are you currently working under a written, board-approved supervision agreement?

☐ YES ☐ NO

IF YES — SUPERVISOR NAME AND CREDENTIAL

HOURS ACCRUED TO DATE

CREDENTIAL YOU ARE WORKING TOWARD

Other training and certifications — CPR, First Aid, CPI or de-escalation, ASAM, Motivational Interviewing, CBT, DBT, EMDR, trauma-informed care, DUI/OVI assessment, EHR systems you have used, anything else:

4 · MEDICAID PARTICIPATION & PROGRAM INTEGRITY SCREENING

Every applicant answers this section, clinical and non-clinical alike. Utopia Therapeutics serves Ohio Medicaid clients, and federal law bars a Medicaid-funded program from employing or contracting with an excluded individual in ANY capacity. A “yes” answer does not automatically end your application — an unreported “yes” does.

Are you currently enrolled as an Ohio Medicaid provider (PNM / MITS)?

☐ YES ☐ NO

IF YES — OHIO MEDICAID PROVIDER ID

ENROLLMENT TYPE

REVALIDATION DATE

Have you ever been excluded, suspended, debarred, terminated, or otherwise sanctioned by Medicare, Medicaid, or any other federal or state health care program?

☐ YES ☐ NO

Are you listed today on the OIG List of Excluded Individuals/Entities (LEIE), the SAM.gov exclusions list, or the Ohio Medicaid Provider Exclusion and Suspension List?

☐ YES ☐ NO

Have you ever been named in a substantiated finding of abuse, neglect, exploitation, or misappropriation of property — on a state registry, by a protective services agency, or by a licensing board?

☐ YES ☐ NO

Have you ever had billing privileges revoked or suspended, or been the subject of a health care fraud, waste, or abuse investigation, audit finding, or repayment demand?

☐ YES ☐ NO

IF YOU ANSWERED YES TO ANY QUESTION IN THIS SECTION, EXPLAIN FULLY — WHAT HAPPENED, WHEN, WHICH PROGRAM OR AGENCY, AND HOW IT WAS RESOLVED.

5 · EDUCATION

HIGH SCHOOL / GED	CITY, STATE	DEGREE / DIPLOMA & MAJOR	COMPLETED?	YEAR
COLLEGE OR UNIVERSITY	CITY, STATE	DEGREE / DIPLOMA & MAJOR	COMPLETED?	YEAR
GRADUATE SCHOOL	CITY, STATE	DEGREE / DIPLOMA & MAJOR	COMPLETED?	YEAR
OTHER TRAINING OR CERTIFICATE PROGRAM	CITY, STATE	DEGREE / DIPLOMA & MAJOR	COMPLETED?	YEAR

6 · EMPLOYMENT HISTORY

Start with your most recent employer and account for the last seven years, including gaps. Include self-employment, contract work, and military service. If you have worked in behavioral health or human services, your most recent clinical supervisor must appear here.

Employer 1 — most recent

EMPLOYER	CITY, STATE	MAIN PHONE		
YOUR JOB TITLE	SUPERVISOR NAME & CREDENTIAL	SUPERVISOR PHONE OR EMAIL		
FROM (MO/YR)	TO (MO/YR)	ENDING PAY RATE	FT / PT / CONTRACT	REASON FOR LEAVING
WHAT YOU DID — CASELOAD, POPULATION, SERVICES DELIVERED, DOCUMENTATION SYSTEM				

May we contact this employer?

☐ YES ☐ NO

Employer 2

EMPLOYER	CITY, STATE	MAIN PHONE		
YOUR JOB TITLE	SUPERVISOR NAME & CREDENTIAL	SUPERVISOR PHONE OR EMAIL		
FROM (MO/YR)	TO (MO/YR)	ENDING PAY RATE	FT / PT / CONTRACT	REASON FOR LEAVING
WHAT YOU DID — CASELOAD, POPULATION, SERVICES DELIVERED, DOCUMENTATION SYSTEM				

May we contact this employer?

☐ YES ☐ NO

Employer 3

EMPLOYER

CITY, STATE

MAIN PHONE

YOUR JOB TITLE

SUPERVISOR NAME & CREDENTIAL

SUPERVISOR PHONE OR EMAIL

FROM (MO/YR)

TO (MO/YR)

ENDING PAY RATE

FT / PT / CONTRACT

REASON FOR LEAVING

WHAT YOU DID — CASELOAD, POPULATION, SERVICES DELIVERED, DOCUMENTATION SYSTEM

May we contact this employer?

☐ YES☐ NO

EXPLAIN ANY GAP IN EMPLOYMENT LONGER THAN SIX MONTHS.

7 · PROFESSIONAL REFERENCES

Three people who are not relatives. At least one must be a supervisor from a clinical or human-services setting. We do contact references before an offer.

REFERENCE 1 — NAME & CREDENTIAL

TITLE & ORGANIZATION

RELATIONSHIP TO YOU

YEARS KNOWN

PHONE

EMAIL

BEST TIME TO REACH THEM

REFERENCE 2 — NAME & CREDENTIAL

TITLE & ORGANIZATION

RELATIONSHIP TO YOU

YEARS KNOWN

PHONE

EMAIL

BEST TIME TO REACH THEM

REFERENCE 3 — NAME & CREDENTIAL

TITLE & ORGANIZATION

RELATIONSHIP TO YOU

YEARS KNOWN

PHONE

EMAIL

BEST TIME TO REACH THEM

8 · DRIVING RECORD

Complete this section ONLY if the position you want involves transporting clients or driving on agency business. Otherwise write N/A on the first line and move on.

DRIVER'S LICENSE NUMBER

STATE

EXPIRATION DATE

DO YOU HAVE RELIABLE TRANSPORTATION TO WORK?

Do you carry current automobile liability insurance?

☐ YES☐ NO

Has your driver's license been suspended, revoked, or restricted in the past five years?

☐ YES☐ NO

LIST ANY MOVING VIOLATIONS OR AT-FAULT ACCIDENTS IN THE PAST THREE YEARS.

9 · CRIMINAL HISTORY

A conviction does not automatically disqualify you. We look at what the offense was, how long ago it happened, what you have done since, and whether it relates to the duties of the position — and we do that individually, as Ohio Revised Code 109.572 and the rules governing behavioral health providers require. Answer honestly: a record you disclose is something we can work with, and a record we find that you did not disclose is not.

Do NOT include: sealed or expunged records · records that were dismissed or resulted in acquittal · juvenile adjudications · minor traffic violations.

Have you ever been convicted of, pleaded guilty to, or pleaded no contest to a criminal offense other than a minor traffic violation?

☐ YES ☐ NO

Do you have any criminal charge pending against you right now?

☐ YES ☐ NO

IF YES TO EITHER — FOR EACH: THE OFFENSE, THE COUNTY AND STATE, THE DATE, AND THE OUTCOME OR SENTENCE.

Do you hold a Certificate of Qualification for Employment (CQE) under ORC 2953.25, or a certificate of achievement and employability?

☐ YES ☐ NO

IF YES — ISSUING COURT AND DATE. ATTACH A COPY; IT MATTERS TO US.

10 · CONDITIONS OF EMPLOYMENT

Read each statement and put your initials in the box to its right.

- I understand that any offer of employment is contingent on a satisfactory Ohio BCI and, where required, FBI criminal records check under Ohio Revised Code 109.572, and that certain offenses are disqualifying by law for positions in a behavioral health program.

INITIALS

- I understand that employment is contingent on verification of my license or certification directly with the issuing board, and that I must keep it active and unrestricted for as long as I hold the position. I will report any board investigation, disciplinary action, restriction, or lapse to Utopia Therapeutics within one business day.

INITIALS

- I understand that I will be screened against the OIG LEIE, SAM.gov, and Ohio Medicaid exclusion lists before hire and monthly thereafter, and that appearing on any of them disqualifies me from employment or contract work in any capacity, clinical or administrative.

INITIALS

- I understand that Utopia Therapeutics is a drug-free workplace, that employment is contingent on a pre-employment drug screen, and that I may be tested on reasonable suspicion or following a workplace accident.

INITIALS

- I understand that I must complete tuberculosis screening and any other health screening required by policy or by rule before I provide direct client services.

INITIALS

- I understand that I will have access to protected health information and to substance use disorder treatment records protected by HIPAA and by 42 CFR Part 2, that I must complete confidentiality training before any client contact, and that unauthorized disclosure is grounds for immediate termination and may carry civil and criminal penalties.

INITIALS

- I understand that I am a mandatory reporter of suspected child abuse or neglect under ORC 2151.421 and of abuse, neglect, or exploitation of adults under ORC 5101.63.

INITIALS

- I understand that Utopia Therapeutics maintains a code of ethical conduct governing professional boundaries, dual relationships, and contact with current and former clients, and that I am also bound by the code of ethics of my licensing or certifying board.

INITIALS

11 · APPLICANT CERTIFICATION & SIGNATURE

I certify that the information I have given on this application, and in any attachment or interview, is true and complete to the best of my knowledge. I understand that a false statement, an omission, or a misrepresentation may result in the withdrawal of an offer or in termination of employment, no matter when it is discovered.

I authorize Utopia Therapeutics to verify the information in this application — including my education, employment history, professional licenses and certifications, and the references I have listed — and I authorize those individuals, employers, schools, and licensing boards to release information about me. I release Utopia Therapeutics, and every person and organization providing information, from any liability for doing so.

I understand that this application is not a contract of employment, and that if I am hired my employment is at will: either Utopia Therapeutics or I may end the employment relationship at any time, with or without notice and with or without cause. No representative of Utopia Therapeutics has authority to change this except in a written agreement signed by the Executive Director.

I understand that a criminal background check and a check of federal and state exclusion lists will be performed, and that a separate written disclosure and authorization will be given to me for the background check before it is run.

APPLICANT SIGNATURE — TYPING YOUR FULL NAME HERE IS YOUR ELECTRONIC SIGNATURE

DATE

PRINT YOUR FULL LEGAL NAME

BEST PHONE

EMAIL

FOR OFFICE USE ONLY — DO NOT WRITE BELOW THIS LINE

Internal screening record. Keep this page with the application in the personnel file; it is the page a CARF or OhioMHAS reviewer will look for.

DATE RECEIVED	RECEIVED BY	POSITION CONSIDERED FOR	SOURCE	
LICENSE VERIFIED (ELICENSE) — DATE & INITIALS	EXCLUSION SCREENING (LEIE / SAM / ODM) — DATE & RESULT		REFERENCES CHECKED — DATE	
BCI SUBMITTED	FBI SUBMITTED	RESULTS RECEIVED	DRUG SCREEN	TB SCREEN
INTERVIEW DATE(S) & INTERVIEWER(S)	DISPOSITION (HIRED / NOT SELECTED / WITHDREW)		DATE	
NOTES				