Office Application for Employment

Dear Applicant:

Please complete and return the employment application along with the Family Care Safety Registry ["FCSR"] Workers Registration form to On My Own, Inc.

If you are unsure if you are registered with FCSR, you can go online and search by your Social Security Number at http://health.mo.gov/safety/fcsr/index.php. If you find you are not registered with FCSR you can then do so by completing the online registration form. The cost when you mail it in is $13.00. It will cost $1.25 more to register online, however the turnaround is usually 24-48 hours when registering online and mailing can take several months for a result. Please note: We only interview individuals registered with FCSR and who have a satisfactory rating.

Both the application and the FCSR form need to be returned regardless if you are already registered with the FCSR or if you register online. We still need to have the information on the FCSR form for internal processing.

Also, please make sure you **bring your Drivers License and Social Security card** so we can get a copy to go with your application and FCSR form.

Thank you.

Main Office
428 E. Highland Ave
Nevada, MO 64772
417-667-7007
800-362-8852

Collins Office
PO Box 211
1301 DeLaPorte
Collins, MO 64738
417-275-1115
877-275-2815

HR Department
Patti Hendrix
417-667-7007 x30
patti.hendrix@omoinc.org

Office Application for Employment

On My Own, Inc.
Non-Residential
Independent Living Center

We are an equal opportunity employer and do not unlawfully discriminate in employment. No question on this application is used for the purpose of limiting or excluding any applicant from consideration for employment on a basis prohibited by local, state, or federal law. Equal access to employment, services, and programs is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of the organization.

Position Applying For:	Date of Application:	Social Security Number:	
Name: Last	First	M.I.	Maiden Name (if applicable):
Address: Street	City	State	Zip Code
Home Phone:	Cell Phone:	E-mail Address (if applicable):	

How did you learn about us? ☐Advertisement ☐Employment Agency ☐Friend ☐Relative ☐Walk-In ☐Other

Have you been employed with us before? ☐ Yes ☐ No
If yes, give date(s) _____

Are you currently employed? ☐ Yes ☐ No
If yes, may we contact your present employer? ☐ Yes ☐ No

On what date would you be available to begin work? _____

What is your availability? ☐ FULL TIME ☐ PART TIME

Would you object to working overtime if necessary? ☐ Yes ☐ No

This job requires consistent regular and punctual attendance; can you meet this requirement? ☐ Yes ☐ No

If you are under the age of 18, can you provide a work permit if it is required? ☐ Yes ☐ No

Are you prevented from lawfully becoming employed in this country because of Visa or Immigration status? ☐ Yes ☐ No (Proof of citizenship or immigration status will be required upon employment)

Have you ever been found or pleaded guilty nolo contendere of a criminal act (minor traffic violations are exempt)?
☐ Yes ☐ No If yes, please explain in detail (a "Yes" response will not necessarily prevent employment.)

_____

_____

DRIVER'S INFORMATION

Can you travel if a job requires it? ☐ Yes ☐ No

Are you currently in possession of Automobile Insurance that meets the statutory insurance requirement for the State of Missouri? ☐Yes ☐ No Is this insurance presently in effect? ☐ Yes ☐ No

Drivers License Number _____Issuing State _____Expiration Date _____Class_____

Do you have any experience working with people with disabilities?

_____

_____

EMPLOYMENT EXPERIENCE

Start with your present or most recent employment. You MUST list at least 5 years of employment history.

Employer Name:	Job Title:
Employer Address:	Description of Job Duties:
Supervisor/Manager Name & Phone Number:	
Dates Employed From: To:	
Wage: $ ______________ per ☐ Hour ☐Week ☐Year	Reason for Leaving:
Employer Name:	Job Title:
Employer Address:	Description of Job Duties:
Supervisor/Manager Name & Phone Number:	
Dates Employed From: To:	
Wage: $ ______________ per ☐ Hour ☐Week ☐Year	Reason for Leaving:
Employer Name:	Job Title:
Employer Address:	Description of Job Duties:
Supervisor/Manager Name & Phone Number:	
Dates Employed From: To:	
Wage: $ ______________ per ☐ Hour ☐Week ☐Year	Reason for Leaving:
Employer Name:	Job Title:
Employer Address:	Description of Job Duties:
Supervisor/Manager Name & Phone Number:	
Dates Employed From: To:	
Wage: $ ______________ per ☐ Hour ☐Week ☐Year	Reason for Leaving:
Employer Name:	Job Title:
Employer Address:	Description of Job Duties:
Supervisor/Manager Name & Phone Number:	
Dates Employed From: To:	
Wage: $ ______________ per ☐ Hour ☐Week ☐Year	Reason for Leaving:

Please explain, in detail, any gaps in your employment history:

____

____

EDUCATION	Elementary School	High School	Undergraduate College/University/Technical	Graduate School
School Name and Location				
Years Completed	**4 5 6 7 8**	**9 10 11 12**	**1 2 3 4 5**	**1 2 3 4**
Diploma/Degree				
Describe course of study				

Summarize any job-related training, skills, licenses, certificates, and/or other qualification:

_____

_____

REFERENCES

Please provide information on three references that are NOT RELATED TO YOU and are NOT PREVIOUS EMPLOYERS.

NAME	ADDRESS	TELEPHONE NUMBER	YEARS KNOWN	RELATIONSHIP TO REFERENCE
1.				
2.				
3.				

I hereby authorize the potential employer to contact, obtain, and verify the accuracy of information contained in this application from all previous employers, educational institutions, and references. I also hereby release from liability the potential employer and its representatives for seeking, gathering, and using such information to make employment decisions and all other persons or organizations for providing such information.

I understand that any misrepresentation or material omission made by me on this application will be sufficient cause for cancellation of this application or immediate termination of employment if I am employed, whenever it may be discovered.

If I am employed, I acknowledge that there is no specified length of employment and that this application does not constitute an agreement or contract for employment. Accordingly, either I or the employer can terminate the relationship at will, with or without cause, at any time, so long as there is no violation of applicable federal or state law.

I understand that it is the policy of this organization not to refuse to hire or otherwise discriminate against a qualified applicant.

_____ _____

Applicant Signature Date

Missouri Department of Health and Senior Services
Family Care Safety Registry

RESET

WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to **Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.**

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent (Agency Name: _____)
- ☐ Child Care
- ☐ Foster Parent/Family Member of Foster Parent (County Office: _____)
- ☐ Hospital
- ☐ Long Term Care/Personal Care (*Please choose subcategory at right →.)*
- ☐ Mental Health/Psychiatric Hospital
- ☐ Voluntary *(Select voluntary if no other registration type applies.)*

A one-time registration fee of **$13.00** applies to all categories except Foster Parents. Foster Parents must list the Children's Division county office.

Register only once. If you believe you have already registered, check our website at www.health.mo.gov/safety/fcsr or call, toll free, 866-422-6872.

Long Term Care / Personal Care Subcategories (Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☐ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☐ Personal Care – In-Home Services
- ☐ Personal Care – Consumer Directed Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

— —

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (Jr., Sr., II, III)

MAIDEN NAME (If applicable)	PRIOR NAMES USED (If applicable, list first and last names.)	DATE OF BIRTH (mm-dd-yyyy)	GENDER
		- -	☐ M ☐ F

CONTACT INFORMATION

MAILING ADDRESS (Enter your street address or post office box. This address must be different from Employer Address.)

CITY	STATE	ZIP CODE	COUNTY

TELEPHONE	EMAIL ADDRESS (Required)	COUNTRY (Complete *only* if U.S. territory/outside U.S.)
( ) -		

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME

EMPLOYER ADDRESS

EMPLOYER CITY	STATE	ZIP

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE
( ) -		

☐ No Employer, because I am a(n):

- ☐ Adoptive Parent
- ☐ Foster Parent/Family Member
- ☐ Home Child Care Provider
- ☐ Private Pay/Private Duty
- ☐ Student
- ☐ Volunteer
- ☐ Other (Explain: _____)

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT (Must be signed in blue or black ink.)	DATE OF SIGNATURE (Must be within six months of submission.)
➤	- -

WHAT IS THE FAMILY CARE SAFETY REGISTRY?

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. **Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor.** Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?

Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select "Voluntary." (A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 *et seq*., RSMo.) If you checked Long Term Care / Personal Care, please *also* make one or more selections from the column on the right for subcategory.

Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

Contact Information – List your address, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Registry may contact you to request a personal email address if one is not provided.

Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right. The employer entered in this section will not receive a copy of the registration notification. Employers eligible to use the Registry for caregiver screenings must make a separate request for your background information.

Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

WHERE DO I SEND MY REGISTRATION FORM?

Send your completed registration form and photocopy of Social Security card and required fee to the **Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102**. If you have questions, please call the Registry using the toll-free telephone number, **866-422-6872**.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your contact information. *Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to fcsr@health.mo.gov, or by mail to FCSR, PO Box 570, Jefferson City, MO 65102.*

WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?

As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the *transfer* of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the *substance* of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).